RESPONSE OPERATING GUIDELINES

MEDICAL EVACUATION

2012

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RECORD OF CHANGES

RESPONSE OPERATING GUIDELINES

MEDICAL EVACUATION

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I. AUTHORITY

See Basic Plan, Section I, and Annex H – Health and Medical. Also, through assignment as primary agency for Health and Medical Emergency Support Function 8 & for the State of Texas in support of Annex C – Shelter & Mass Care and Annex E – Evacuation.

II. PURPOSE & SCOPE

A. PURPOSE

1. The Texas Department of State Health Services, in cooperation with the Texas Division of Emergency Management, has developed this guideline to provide direction to communities and response partners during the evacuation of the medical population during catastrophic events. Although most facilities that care for persons with medical needs are required to have an evacuation plan, there is a strong probability that during an evacuation due to a catastrophic event, some facilities may not be able to execute these plans without the support of local, regional, state and federal partners. If a community requires assistance to evacuate their hospitals, nursing homes, or home health patients, the facility managers and staff and all levels of emergency response (local, state and federal) must work together to provide a well-coordinated and efficient evacuation process.

2. This document outlines the various agencies, assets, and operational processes that may be involved in a large-scale evacuation of medical citizens during an emergency event. It describes the roles that local, state and federal partners play in the evacuation process and it describes the various components involved in the evacuation process. This guideline is not meant to supplant local activities but it will provide the framework in which various emergency response agencies will work together to operationalize the response activities associated with a large scale evacuation.

3. The *Response Operating Guideline, Medical Evacuation 2012* will be utilized when local emergency management resources and assets are overwhelmed by the impact of a catastrophic event. It will be utilized to coordinate the needs of the evacuating region's healthcare facilities with efforts of all supporting local, State, and Federal agencies.

B. SCOPE

The *Response Operating Guideline Medical Evacuation 2012*, though suitable for most hazards, is primarily focused on evacuations of medical patients located in coastal communities threatened by a hurricane and located in surge or flood zones. This plan incorporates the steps necessary to provide support to evacuate hospitals, nursing homes and home health patients in a large-scale disaster. The *Response Operating Guideline, Medical Evacuations 2012* also provides guidance to facilities that have taken steps to "shelter-in-place".

III. ACRONYMS & DEFINITIONS

NOTE: These terms and definitions listed below are for descriptive purposes and may not match the terminology of local response professionals.

A. ACRONYMS

CMOC	Catastrophic Medical Operations Center – Houston
DDC	Disaster District Chairman
DSHS	Department of State Health Services
MOC	Medical Operations Center
NDMS	National Disaster Medical System
RMOC	Regional Medical Operations Center – San Antonio

SMOC	State Medical Operations Center
SOC	State Operations Center
TDEM	Texas Division of Emergency Management

B. **DEFINITIONS**

Action Request Form (ARF) – An "*Action Request Form"* is the actual form that the state uses to make a request for support from the Federal Government. Requests for federal support will be processed through the State Operations Center (SOC) and submitted by either TDEM or DSHS through the designated person at the State Operation Center.

Aeromedical Marshaling Point (AMP) – is a state/federal designated evacuation point at an airport that is being utilized for medical population evacuation efforts. The AMP provides the specific point where people with medical needs will be transported to at a designated Air Hub. Generally, patients will be transported to the Air Hub via ambulance. Once transferred to the Air Hub and transferred to the medical staff in the AMP, the patient is triaged, prepared for air travel and transferred to an awaiting air asset. They are then flown to designated receiving airport or an NDMS Federal Coordinating Center (FCC) receiving site, where they are triaged and transfer to a receiving NDMS Hospitals by the supporting Veterans Administration or Department of Defense FCC.

Air Hub – an Air Hub refers to the airport that has been designated as a collection point for medical patients that will be evacuated out of a region that has been impacted or could be impacted by a pending disaster. An Air Hub can be established by Texas Military Forces or by NDMS or by both. The Air Hub will have numerous supporting agencies that work together to effectively and efficiently coordinate the movement of medical patients from transporting ambulances into the AMP and eventually on to the transporting aircraft. The military term for an Air Hub is Aeromedical Point of Evacuation (or APOE).

Air Hub Ambulance Transportation Team (AHATT) – This specifically refers to response personnel and Ambulance Strike Teams responsible for the management of the movement of medical patients from a healthcare facility to the Air Hub.

Air Hub Triage Point or Patient Reception Point – The specific location at an Air Hub where EMS transfers evacuating patients to the air medical transport crews in the AMP.

Ambulance – Medical transportation vehicle capable of transporting up to two patients in a recumbent position. An Ambulance will have either Advanced Life Support (ALS) or Basic Life Support (BLS) capability.

Ambulance Providers – This includes the local EMS ambulances and all regional, state and federal ambulances brought into a response to provide transportation assets to a large scale medical emergency event.

Ambus – An specialty ambulance built upon a bus platform that, depending on the configuration of the unit, has the capability to transport up to twenty (20) patients,. These vehicles are staffed with medical personnel and equipment similar to a standard ambulance. They are used for mass casualty events and large scale patient transfers of hospital patients and nursing home patients. There are multiple units assigned to EMTF regions across Texas.

Ambulance Staging Area – Location where medical transportation assets are pre-positioned, checked in, provided mission assignments, provided rest and rehab, and demobilized. The initial Staging Area for hurricane deployment is the Alamo Regional Command Center - ARCC in San Antonio. Multiple Staging Areas can be established.

Ambulance Staging Manager(ASM) – a team of medical professional capable of providing overall management of an Ambulance Staging Area for large scale deployments of medical transportation assets.

Ambulance Strike Team – a NIMS compliant configuration of five ambulances, assigned to a Strike Team Leader, with common communication capabilities. DSHS deploys ambulances as a Strike Team to assist in overall management of the EMS Units. These teams can be assembled at their dispatch point, at a Staging Area or by the local Incident Commander.

Ambulance Strike Team Leader (ASTL) – a suitably qualified EMS professional trained to effectively manage and direct an ambulance strike team responding to an event.

ARCC – Alamo Regional Command Center in San Antonio, Location of the RMOC.

Command Assistance Team (CAT) – a designated team of medical professionals employed with DSHS that have been trained to respond to and provide support to the Health Service Region impacted by a disaster.

Comfort Stations – designated sites along evacuation routes that provide support to the general population including rest stations, bathroom facilities, water, and limited medical support capabilities.

Critical Care Air Transport Teams (CCATT) – a DoD medical team that provides in-flight care to critical patients who are electrically or ventilator dependent or require intensive care support. Each CCATT team is comprised of an intensivist, a critical care nurse and a respiratory technician.

Department of State Health Services (DSHS) – the lead agency in Texas responsible for public health and medical Emergency Support Function (ESF)-8 support activity.

Disaster District Committee or Disaster District Coordinator (DDC) – The DDC is a TDEM regional command and control facility that consists of state/regional response agencies in support of local EOCs. DSHS provides support to the District Medical Operation Center (MOC) that supports the DDC for all public health and medical activities. The DDC is usually the first point of contact for the DSHS Rapid Assessment Teams (RAT) and the Medical Incident Support Team (MIST).

District Medical Operation Center (DMOC) – The ESF-8 Public Health and Medical "command, control and communication" component that supports a region's Disaster District Coordinator. The DMOC provides the regional support for integration of state medical assets into the local response environment, support to the Health Service Region and local health departments, coordination of medical evacuation (ground and air), and other public health and medical support as directed by the DDC or State SMOC.

Division 1 – Texas coastline from Matagorda County north (including Matagorda County).

Division 2 – Texas coastline south of Matagorda County.

Embarkation Point – A designated site set up by local officials and the DDC, used as a loading point for people requiring transportation out of a disaster area. The embarkation point should have a medical triage capability and be supported by medical ground transportation assets.

Emergency Management Assistance Compact (EMAC) – An "Emergency Management Assistance Compact" is the actual document that the state uses to make a request for support from another state. Requests for state support will be processed through the State Operations Center (SOC) and submitted by TDEM through the designated person at the State Operation Center.

Emergency Medical Task Force (EMTF) – an emergency response capability built by DSHS and supported by local emergency response teams and assets. Each EMTF team is managed by a regional EMTF Coordinator. These eight (8) regional Emergency Medical Task Force teams have four response capabilities:

- Ambulance Strike Teams
- Ambus (Up to two per region)

- Mobile Medical Units (MMU)
- Nurse Strike Teams

Emergency Operations Center (EOC) – Local emergency command and control facility that provides coordination of response efforts during significant incidents and events.

ESF-8 Public Health and Medical – Emergency Support Function 8 is one of seventeen categories established by the federal government that align categories of resources and provide strategic objectives for their use. The ESF's designate which agencies have the responsibility to perform the specific tasks during a disaster. The Texas Department of State Health Services is the lead agency in Texas for ESF-8 Public Health and Medical support.

ESF-9 – Emergency Support Function 9 is for urban search and rescue. This function is managed by Texas Task Force 1 and Texas Task Force 2, the two primary urban search and rescue teams in Texas.

Evacuation Triage Teams – The mission of the personnel on the Triage Team is to integrate with local jurisdiction triage personnel and assist with the triage of medical patients for appropriate transportation needs and sheltering placement.

Facility Evacuation Team – staff and assets utilized to coordinate the movement of patients within a healthcare facility to a sister facility, non-affiliated facility or transportation hubs. They determine which people to evacuate and prepare them for the transfer to the transportation asset.

Facility Patient Load Officer – staff responsible for triaging individuals and validating the number of patients requiring transportation and the level of transport assistance that is needed. They coordinate with the local Emergency Operation Center (EOC).

Facility Triage Point – a location at the healthcare facility where the Facility Load Officer and the Ambulance Strike Team Leader coordinate the order and sequence in which triaged patients are loaded onto medical transportation assets.

Federal Coordinating Center (FCC) – A reception point at a designated airport that has been established as a receiving location for NDMS patients and civilians with medical needs that are moved utilizing federal medical transportation assets as the result of a large-scale disaster. Texas has four (4) and utilized Dallas/Ft. Worth and El Paso during hurricane evacuations.

Global Patient Movement Requirements Center (GPMRC) – The GPMRC authorizes transfers to medical treatment facilities of the Military Departments or the Department of Veterans Affairs and coordinates inter-theater and inside the continental United States patient movement requirements with the appropriate transportation component commands of US Transportation Command. While the GPMRC is the Department of Defense single manager for the regulation of movement of military patients, mostly from overseas, it also has a mission to assist federal authorities inside the continental United States in case of natural or man-made disasters, under the system that local emergency responders refer to as NDMS.

H-Hour – the time at which tropical storm force winds touch the Texas coast. Most activities are expressed in terms of how long before H-Hour they are occur. (Note: this estimated time frame is updated constantly and is displayed in WebEOC in the SOC Clock).

Litter Bus – A school bus that has been specifically "converted" to provide transportation of medical patients who cannot tolerate sitting for long periods of time. This vehicle is staffed with a combination of EMTs, paramedics, and nurses and is equipped with assorted medical equipment to provide care and support to patients during transportation. These assets are "last resort" transportation assets that are utilized when other transportation choices such as Ambulance, Ambus, and Air assets may not be an option.

Medical Bus – A "coach-style" bus utilized by the Texas Division of Emergency Management (TDEM) and the Department of State Health Services (DSHS) to provide ground transportation to medical patients who have been medically triaged and determined to be able to tolerate transportation in a sitting, semi-reclined position for long periods of time. This medical transportation

asset is staffed with medical personnel and medical equipment to provide supportive care to patients during evacuation.

Medical Incident Support Team (MIST) – The Medical Incident Support Team is a trained liaison team of emergency response professionals with medical expertise that are pre-deployed to DDCs and local EOCs to coordinate the integration of state and federal medical assets into an area impacted by a disaster. The MIST personnel are some of the first representatives of the public health and medical (ESF-8) response efforts that DSHS deploys to an emergency incident.

Medical Patient – A person with some type of medical condition that requires a prescribed level of medical care, support or assistance.

Medical Triage – A term used during a disaster that refers to the process of applying the prioritizing of medical patients for during an evacuation. The medical triage has two applications, first – for determining which type of medical transportation is appropriate, second – to determining what type of medical facility is most appropriate.

Mobile Medical Team – The Mobile Medical Team is a DSHS supported Strike Team of medical professionals with emergency response expertise that respond to an event and provide appropriate medical assessments and triage, treatment for acute illness and minor injury, treatment and stabilization of underlying chronic medical, mental health, force protection of responders, substance abuse conditions, and patient stabilization for transport during emergency response operations

MOC – Medical Operations Center – A command node that brings together representatives from local health systems, and supporting State and federal supporting agencies to coordinate and streamline the a region's healthcare response during a disaster. A MOC can be established in both affected and reception jurisdictions.

CMOC – Catastrophic Medical Operation Center.in Houston Texas. This MOC is utilized by DSHS as an additional, command, communications and coordination element in Division 1.

RMOC – Regional Medical Operation Center in San Antonio Texas. This MOC is utilized by DSHS as an additional, command, communications and coordination element in Division 2.

Mobile Aeromedical Staging Facilities (MASF) – A military asset that provide patient holding capability and patient care at the Air Hubs. The MASF receives people with medical needs at the Aeromedical Marshaling Point (AMP) and triages patients for airworthiness and ensures patients are properly "packaged" and loaded onto federal NDMS air transportation assets.

Multi Agency Coordination Center/System (MACC) – a multi-agency coordination system responds to requests for resources and support from a local jurisdiction. The Multi-Agency Coordination Center supports response activities that across regions by centralizing and coordinating resource requests and identifying resources that can be obtained from surrounding jurisdictions. It does not have command and control responsibility. The MACC provides a formalized process for mutual aid from county to county.

National Disaster Medical System (NDMS) – provides additional support to State and local medical agencies responding to the health effects of peacetime disasters, terrorism, and weapons of mass destruction. NMDS provides medical response, patient movement, and definitive care capabilities.

Patient Movement Request Form (PMR) – The document that lists medical patients and their medical acuity that need to be evacuated utilizing state and federal medical ground and/or medical air transportation. It is the key document used by DSHS, NDMS, and TxMF to properly process and develop mission assignments for TxMF and NDMS military air transportation assets.

Para-transit vehicle – vehicle capable of transporting mobility impaired persons.

Rapid Assessment Team (RAT) – A team of highly skilled personnel within DSHS that are trained to respond to a disaster threat or event to support the Health Service Region in their mission to conduct needs assessments and assist local and regional emergency responders in the coordination of the ESF-8 response for the agency.

Reception Centers (Air) – A designated area in a receiving community that will be prepared to receive medical patients being sent from an evacuating area by air. This site will provide medical triage, palliative care, and will provide transportation for arriving patients to awaiting shelters, nursing homes, hospitals or other facilities as appropriate. A NDMS receiving site at an airport is called a Federal Coordination Center or FCC.

Reception Centers (Ground) – A designated area in a receiving community that will be prepared to receive medical patients being sent from an evacuating area by ground transportation. This site will provide medical triage, palliative care, and will re-direct patients to shelters, nursing homes, hospitals or other facilities as appropriate.

Shelter-in-Place (SIP) – A safety strategy that requires the occupants of a facility to remain in place while the threat or event passes by.

State Medical Operations Center (SMOC) – The SMOC is managed by DSHS and functions as the State Operation Center (SOC) interagency public health and medical operations center. The SMOC's purpose is to coordinate public health and medical care response activities above the field level, and to prioritize incident demands for critical or competing resources. The SMOC facilitates communications between the necessary local, regional, state and federal entities to assemble the assets required to respond to and resolve requests for state public health and medical care assistance. The SMOC includes representatives from DADS, DARS, and DFPS.

SOC – State Operations Center

Temporary Fuel Sites – designated fueling sites along evacuation routes. These sites also provide some medical support (primarily oxygen resupply) to medical transportation assets.

Texas Division of Emergency Management (TDEM) – TDEM is the lead agency in Texas for all aspects of emergency response. The Chief of TDEM coordinates all response activity and directs ESF agencies that support any statewide emergency response.

Texas Military Forces (TxMF) – a combination of Army National Guard, Air National Guard and Texas State Guard whose mission is to provide assistance and security to Texas in times of need.

Texas Emergency Tracking Network (TexasETN) – the Texas Emergency Tracking Network is a web based, internet accessible system that provides emergency responders a way to record and document the people that they are assisting (be it by sheltering or providing transportation) during a disaster. The TexasETN integrates the Radiant Tracking System and other internet information systems like EMSystems and WebEOC together so that they can share data entered into one with the other systems. All people provided state transportation or sheltered within Texas are recorded into TexasETN.

IV. SITUATION & ASSUMPTIONS

A. **SITUATION:**

1. Hospitals, nursing homes, ambulatory care centers, home bound medical patients, and other facilities that provide medical/health care may be:

    a. Damaged or destroyed in major emergency situations

    b. Unable to operate normally because of a lack of utilities or because staff are unable to report for duty as a result of personal injuries or damage to communications and transportation systems

c. Overwhelmed by the "walking wounded" and seriously injured victims transported to facilities in the aftermath of a disaster.

2. Uninjured persons who require frequent medications such as insulin and anti-hypertensive drugs, or regular medical treatment, such as dialysis, may have difficulty in obtaining these medications and treatments in the aftermath of an emergency situation due to damage to pharmacies and treatment facilities and disruptions caused by loss of utilities and damage to transportation systems.

3. Hospital administrators and government officials are all cognizant of the fact that movement of any critical care patient from a hospital to any other venue increases morbidity and mortality risks. During a response to a hurricane this fact and the lack of precise predictability of a storm's landfall 48-72 hours pre-event make the decision to evacuate any facility a difficult yet critically important decision.

4. Because of the inherent risks that people with medical needs face during the evacuation of a medical facility certain critical-care patients should not be moved unless absolutely necessary. Experts in emergency management and health care endorse the concept of sheltering-in-place and support efforts to harden structures so that patients may be safely sheltered in place.

B. ASSUMPTIONS

1. Most communities have adequate local response capability to meet most emergency situations.

2. Health care facilities have viable emergency evacuation plans.

3. The administrators of each healthcare facility, in close coordination with their local officials and emergency management, determine the need to evacuate or shelter-in-place.

4. If hospitals, nursing homes, and homes with people with medical needs are threatened or impacted by a disaster, it may be necessary to relocate significant numbers of patients to other comparable facilities elsewhere.

5. Local and regional authorities will utilize the capabilities of volunteer (Medical Reserve Corps (MRC), Citizen Corps, Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), professional associations, and other non-governmental agencies to provide support the response to the emergency.

6. A large scale catastrophe could force the evacuation of so many people with medical needs that a community will have to obtain additional medical transportation assets, response personnel and medical support teams from local, regional, state and federal response partners.

7. The scope and severity of the emergency, as well as other direct or indirect threats presented by the emergency, will determine which patients/facilities will be evacuated and which air hubs and embarkation sites will be activated to facilitate the evacuation efforts.

8. The procedures for evacuation outlined in the "Response Operating Guideline Medical Evacuation 2012" are primarily designed to be used during events that receive a state or federal declaration of disaster.

9. The intent of the "Response Operating Guideline Medical Evacuation 2012" is to provide a roadmap to assist in the evacuation efforts of the local healthcare facilities and home bound medical population, by coordination emergency operation activities of local responders with the supporting local, state, or federal agencies.

10. The "Response Operating Guideline Medical Evacuation 2012" does not provide for the simultaneous evacuation of medical facilities in all coastal counties. This means that available assets will be distributed based on continuous threat analysis.

11. All requests for assistance related to the evacuation of a community's medical   population and medical facilities will follow the normal channels of requests for support from the community

through to the County, the regional DDC, the State Operations Center (SOC) and Federal Government (see Attachment 6).

12. Once a formal request is received and approved, state and federal agencies will be focused on providing support to regions that make the decision to evacuate their medical facilities and home bound medical population, and to assist in providing support for the care of the medical population that was either evacuated or took steps to "shelter-in-place".

V. CONCEPT OF OPERATIONS

A. GENERAL

1. All medical evacuation response operations will follow the National Incident Management System (NIMS) and the National Response Framework (NRF) structure.

2. When a catastrophic event occurs or is pending (such as a hurricane response) with the potential for serious impact on the health and safety of people in Texas, DSHS will activate the DSHS State Medical Operation Center (SMOC). The SMOC will monitor the incident, maintain contact with the impacted jurisdiction, facilitate the processing of local requests for assistance, and act as a liaison to other supporting state agencies, ESF-8 partners in other states, and our federal and private partners.

3. In certain disasters or public health emergencies, DSHS may determine the need to preposition state medical assets and personnel prior to receiving a local request for support..

4. Local requests for equipment, supplies, and personnel should be made according to established protocols for emergency assistance requests as outlined in the State of Texas Emergency Management Basic Plan. This should be done in coordination with emergency management officials, the Local Health Department (LHD) or Health Service Region (HSR) office in counties without local health departments.

5. Activation criteria *during a hurricane*: The "Response Operating Guideline Medical Evacuation 2012" provides information to assist local, state and federal responders deliver a well-coordinated response to a potential event. The operation activities that will be carried out will be determined based on the following criteria:

   a. Strength of the Storm – The strength of a storm is determined by many characteristics including the size of the storm, the wind speed of the storm, potential storm surge, and speed that the storm is traveling.

   b. Direction of the Storm – The unpredictable nature of a storms path forces local, state, and federal emergency management leaders to make decisions on potential impact areas based on what weather experts call a "cone of error". Geographic Regions within this "cone of error" receive the highest priority considerations. In order to protect and evacuate as many people as possible a stronger storm may force officials to move patients on a "maybe" event.

   c. Local Factors – A decision by local officials to enact a voluntary or mandatory evacuation will also impact facilities efforts to acquire assets and maintain staff during an evacuation effort. This may require a facility to evacuate even though the structure is designed to withstand the potential impact of the storm.

B. OPERATIONAL PHASES

The following are guidelines to facilitate coordination, interagency communications, and operational functionality during the four phases related to a disaster response, including awareness, preparedness, response, and re-entry. Healthcare facilities are responsible for having evacuation plans, including contracts or agreements in place to execute them. However, large-scale medical evacuation of an entire region or multiple regions will require private, local, state, and federal assets to accomplish the mission. Individuals with medical needs have the responsibility to self-evacuate

whenever possible. Those who cannot self-evacuate may require assistance from the city/county and other local entities. If local counties are overwhelmed by the demand for medical evacuation, assistance from the state and federal ESF-8 partners will be required. State and federal assistance includes all agencies and their operating teams required to successfully execute a medical evacuation and sheltering plan.

1. Awareness Phase

   During this phase, state and federal ESF-8 partners review current response plans, with a focus on identifying and filling resource gaps. Transition out of the awareness phase is contingent upon multiple factors including notification of an incident or potential emergency.

2. Preparedness Phase

   This phase begins when there is a notification of a significant incident and the resources of the state and federal government may be requested or, during hurricane season, a tropical depression/storm enters the Gulf of Mexico, the storm's five-day cone touches Texas coast, or the storm's intensity reaches a Category Three while having the potential to impact the Gulf Coast. Once an emergency declaration is made by local, state, or federal officials, resources and assets will begin to stage and deploy to designated locations in order to assist the affected areas. The intensity, available resources, and projected track of the storm will determine the amount of ESF-8 assets deployed.

   The Texas Division of Emergency Management (TDEM) will activate the SOC and the Department of State Health Services (DSHS) will activate the DSHS SMOC. If Federal support agencies (FEMA Region VI, National Disaster Medical System (NDMS), DoD, et al) activate and respond they will co-locate and coordinate ESF-8 activities in the SOC and the DSHS SMOC. Preparedness activities include:

   a. The ESF-8 staffing at the SOC and the DSHS SMOC will be determined by response requirements and validated state requests.

   b. State and DSHS H-120 hour plans are activated and appropriate action steps initiated.

   c. The SOC and DSHS SMOC, in coordination with federal partners and local officials, determine which regional medical staging areas, Air Hubs, and Medical Shelters may/will be activated.

   d. The potential impacted Health Service Regions and Trauma Service Areas establish communication processes with the DSHS SMOC in order to coordinate all ESF-8 response activities.

   e. Medical Facilities:

      1) Review their evacuation plans and determine which patients can be discharged if necessary, which patients may shelter-in-place, and which patients may require evacuation.

      2) Organize clinical staff for shelter-in-place capability.

      3) Hospitals may cancel elective surgeries to reduce patient total.

      4) Alert their predetermined transportation contractors to prepare to deploy assets to support evacuation.

      5) Alert and maintain communications with their receiving facilities.

   f. Local 911 providers continue to respond to 911 requests, identify the assets they will need to augment their operations, and identify where outside support assets and agencies will report.

g. Coordination with other Emergency Support Function partners is initiated in preparation for evacuation and sheltering.

h. The DSHS mobilizes ambulances from outside the possible zone of impact to medical staging points to integrate with local 911 providers (Note: the initial State Staging location for medical transportation assets is at the San Antonio Alamo Regional Command Center (ARCC). These assets are then assigned to the DDC region(s) for further deployment on "Mission Assignments" into local jurisdictions.

i. DSHS SMOC notifies medical response teams for potential deployment.

   1) Rapid Assessment Team (RAT)

   2) Medical Incident Support Team (MIST)

   3) Ambulance Staging Managers (ASM)

   4) EMTF Coordinators and Ambulance Staging Strike Teams

   5) Mobile Medical Team (MMT)

j. Federal ESF-8 will alert its partners to prepare for deployment to Texas to support evacuation and shelter operation.

   1) Once Action Request Forms (ARF's) are received from the state and approved at the federal level, contracts are activated for Federal ambulances, para-transits and coach buses. Once the State of Texas or county officials order a mandatory evacuation and after a Pre-Landfall Presidential Emergency Declaration, Federal assets (including Federal Medical Station material caches and personnel) deploy to augment state and local assets.

   Note: Action Request Forms are submitted through the State Operations Center. Only the TDEM and DSHS fill out and file ARFs. For DSHS, the Operations Section will obtain the necessary operational information, fill out the ARF, and file it through the State Operations Center.

   2) If a military air evacuation is initiated HHS will alert NDMS for: possible deployment of teams, evacuation of patients, and reception at the designated FCC. Once deployment orders are issued, DoD, the lead agent for evacuation transportation within the NDMS, provides assets required to evacuate patients from Air Hubs to a Patient Receiving Area (PRA) as determined by the Medical Interagency Coordination Group (MIACG).

   3) HHS will stage NDMS teams to assist at the Medical Shelters, Air Hubs, and Federal Medical Stations (FMS) as required.

   4) In conjunction TDEM staging Operations in San Antonio, DSHS SMOC activates initial medical staging operations.

3. Response Phase

This phase begins with the mandatory order to evacuate provided by the County Judge or Mayor as appropriate. The storm intensity and location will dictate the extent of the evacuation and destination of evacuees.

a. Initial evacuation efforts will primarily focus on ground transportation. Medical facilities, including hospitals and nursing homes will decide whether to evacuate, shelter-in-place, or a combination of both. The home bound medical population will receive evacuation orders from local officials.

   Note: Air operations will be initiated only if ground transportation efforts are unsuccessful or cannot meet the demand for evacuation of the medical population. Federal NDMS Air

operations are a last resort effort to move people with medical needs out of an impact site. See *Air Operations* Section for details.

b. All medical facilities will provide their respective Emergency Operations Center/Medical Operations Center (EOC/MOC) with key information of their status as requested by their EOC/MOC.

   1) Local and state officials will determine where to locate Medical Shelters and Federal Medical Stations (FMS) to be available to receive medical population. **See the DSHS Response Operating Guideline – Medical Sheltering for details.**

   2) People with medical needs that live amongst the general population will either self-evacuate or, if unable to do so, evacuate from Embarkation Points utilizing local, state and federal transportation assets. Those home bound people with medical needs that cannot self-evacuate must notify their respective EOC or 2-1-1 providers to request evacuation assistance. The medical population evacuated on state assets will be transported to a safe facility within their jurisdiction or to a receiving jurisdiction and directed to an appropriate facility based on medical needs. (FNSS shelter, a Medical Shelter, nursing home, or hospital).

   3) Evacuating Medical facilities that require assistance request ground evacuation through their local EOC/MOC. Coordination of the dispatch of ground transportation assets to a facility is coordinated through the local EMS system and the EOC/MOC. If local EMS requires augmentation, the EOC/MOC will coordinate with the regional DDC/DMOC and the Medical Incident Support Team (MIST) to obtain additional resources from the designated Ambulance Staging Area. Any additional support needs for medical transportation assets are forwarded to the regional DDC and up the chain to the DSHS SMOC Evacuation Branch. All facility evacuations and patient movements are reported to the respective EOC, DDC, and SOC (DSHS SMOC) via the designated process.

c. The DMOC and the MIST personnel will coordinate all transportation missions with the DDC, EOC and embarkation points.

   1) When deployed, medical transportation assets such as ambulance strike teams and medical buses will depart simultaneously from the staging area, in a Medical Transportation Strike Team format.

   2) When medical transportation assets arrive at a medical facility, the facility's *Facility Patient Load Officer* will work with the Ambulance Strike Team Leaders to coordinate the loading of patients onto ambulances and buses. Upon completion of the evacuation of the facility the Ambulance Strike Team Leader or the Load Officer will notify all appropriate EOCs (local) and DDCs (regional). Patients will be transported to medical shelters, receiving jurisdictions, long term care facilities, hospitals, and Air Hubs as appropriate.

d. Local jurisdiction should not have an expectation that state and/or medical transportation assets will remain available within their jurisdiction indefinitely.

   1) Between 18 and 12 hours prior to the onset of tropical storm force winds touching the coast of Texas, all patient evacuation operations (ground and air) will cease.

   2) At this point, if required, Urban Search and Rescue (USAR) Operations will begin. No later than H-12 all aeromedical response personnel will begin movement out of the impact area and into a safe haven.

   3) When the hurricane passes and it is presumed safe, search and rescue evacuation and/or rescue operations will resume.

e. Search and rescue of medical facilities needing evacuation post storm will commence, with those most needing rescue retrieved first (Smart SAR). This activity will be coordinated through Texas Task Force 1 and other supporting SAR support agencies. Ambulance Strike Teams and Ambulance Strike Team Leaders will be deployed with the Texas Task Force 1 and USAR teams to assist in their rescue operations.

f. Damage assessments of facilities and Medical Needs Assessments will be conducted for all medical facilities in coordination with other remaining response requirements identified by the regional, state and federal assessment teams.

4. Re-Entry Phase

This phase is initiated as soon as possible after the event has occurred. In a hurricane this occurs after tropical storm force winds have subsided. The State of Texas has developed specialized teams of emergency response experts from multiple Emergency Support Functions (ESFs) that are deployed into the disaster area to do damage and needs assessments. These response personnel, operating under the authority of the State of Texas, will be activated by the Texas Department of Public Safety Assistant Director, Emergency Management or his/her designee, when deemed appropriate. The response personnel assist local authorities by assembling, entering, and coordinating the resources necessary for the provision of:

a. Security of the involved area

b. Acute medical care

c. Mass care

d. Support of sheltering needs

e. Additional evacuation and/or medical transportation support

f. Re-establish vital infrastructures during the pivotal time period immediately following a devastating storm or other significant event.

g. Re-population (return) of evacuated citizens.

C. **DSHS RESPONSE ACTIVITIES**

When a large scale disaster impacts a community the ability to provide care and/or evacuate large numbers of people with medical needs can severely challenge a community's medical response system. In some disasters the effort to safely move the medical needs population out of harm's way will often necessitate the need for the combined resources of local, state and federal response partners. With a finite amount of ground and air medical transportation assets, all emergency response professionals must work together to effectively manage these critical assets and safely evacuate the medical population from hospitals, nursing home, home health, embarkation points, and Air Hubs.

Numerous processes and procedures utilized by the supporting response agencies will be presented in this guideline. Although the complexities of each agency's missions may not be described in detail there should be enough information included in this document to give local emergency response professionals an understanding of how the various supporting agencies are brought in to provide support to the medical evacuation effort

1. Initial Response

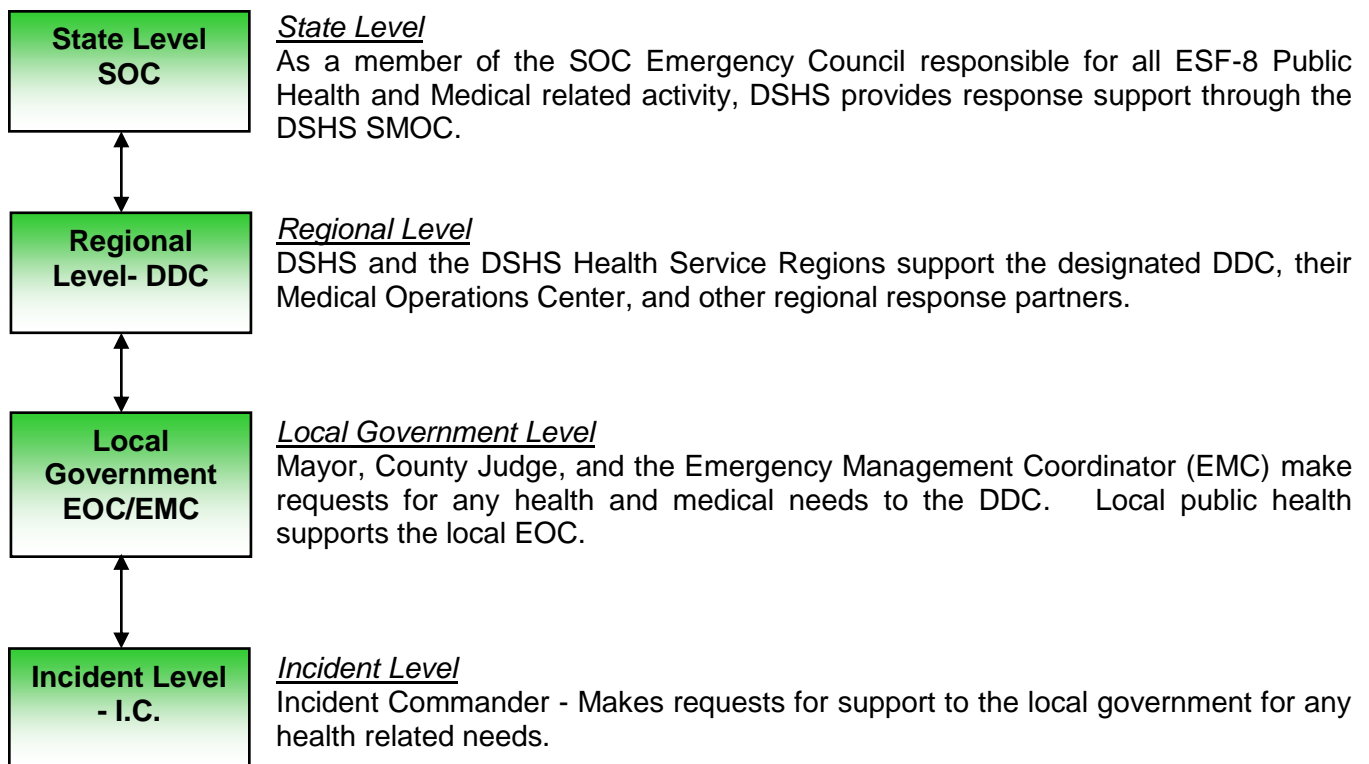For a no notice event the DSHS response activities will be initiated once DSHS is aware of the emergency. For a notice event like a hurricane, DSHS will align its response with the State Operation Center, utilizing pre-established time lines to initiate operational actions. Although each and every disaster delivers a unique set of challenges the *initial* operational response activities are similar:

a. Establish situational awareness and conduct a needs assessment

b. Develop an operation command structure for the event and establish communication links with all supporting agencies

c. Procure and deploy the necessary assets identified during the needs assessment that will support the local operational response

d. Initiation of operational response activities and monitor the emergency events and adapt the response operations accordingly

2. Establish Situational Awareness/Needs Assessment

As the state's designated lead agency for ESF-8, the Department of State Health Services provides health and medical support during a catastrophic disaster or health emergency. For disaster events that would require a large scale evacuation like a major earthquake, flooding, or hurricane, DSHS works with local, regional, state and federal partners to provide assistance and support to the impacted regions.

The Department of State Health Services (DSHS) establishes situational awareness and starts the process of building an appropriate operational response by activating and/or deploying the following:

a. DSHS activates the DSHS SMOC and this serves as the State Medical Operation Center. Located at the main campus (1100 W. 49th Street, Austin, Texas), the DSHS SMOC supports the SOC for ESF-8 allocation of resources and provides coordination and communication of all ESF-8 activities within the State of Texas

   1) Establishes communications with Health Service Regions

   2) Coordinates with the SOC and the Texas WebEOC Interoperability Project (TWIRP) to create a Statewide WebEOC Incident to integrate with all WebEOC instances that will be effected by or supporting the incident and assists in the activation of the TexasETN

   3) Establish communication links with District MOCs that will be impacted or are activated to provide support to the DDC and DSHS.

      a) Activates the Catastrophic Medical Operations Center (CMOC) located in Houston for Division 1 as appropriate for state level activities

      b) Activates the Regional Medical Operation Center (RMOC) located in San Antonio for Division 2 as appropriate for state level activities

b. RAT and MIST: DSHS has developed numerous response teams that will be activated to respond to an impacted region to provide assistance and support. Two of the first DSHS teams to be activated and deployed into a region will be the Rapid Assessment Team (RAT), and the Medical Incident Support Team (MIST).

   1) The RAT works with local officials and the DDC to conduct an assessment of the impact the event will have on public health systems and develops situational awareness for the SMOC to determine what the support needs are.

   2) The MIST are deployed to an evacuating region to work with response officials in the DDC-MOC and EOC-MOC, to coordinate the requests for transportation of medical needs people, coordinate the staging of medical transportation assets, manage the assets, and coordinate the evacuation and tracking of people with medical needs out of harm's way to a safe location.

3. Develop ESF-8 Operation Command Structure

State Level SOC	*State Level* As a member of the SOC Emergency Council responsible for all ESF-8 Public Health and Medical related activity, DSHS provides response support through the DSHS SMOC.
Regional Level- DDC	*Regional Level* DSHS and the DSHS Health Service Regions support the designated DDC, their Medical Operations Center, and other regional response partners.
Local Government EOC/EMC	*Local Government Level* Mayor, County Judge, and the Emergency Management Coordinator (EMC) make requests for any health and medical needs to the DDC. Local public health supports the local EOC.
Incident Level - I.C.	*Incident Level* Incident Commander - Makes requests for support to the local government for any health related needs.

a. The State of Texas has developed a medical command structure that allows local government to effectively manage their response efforts while working with the state to acquire additional support and assets. Any and all requests for assistance from a local government must follow this established state process. Utilizing this process during a response to a disaster will provide more effective incident management, improve communication processes, and assist the state and federal government in responding to and coordinating the requests for assistance and support.

   1) Designated representatives from the Department of State Health Services Health Service Regions and the RAT and MIST response teams will meet with the DDC and EOC officials as appropriate to formalize the communication processes for health and medical related operations. The designation of a formal Medical Operations Center (MOC) within the EOC and/or DDC will help develop the necessary communication links between local response agencies and all supporting state and federal agencies that will respond to support health and medical activities. In addition to this established state process, the Department of State Health Services has developed an ESF-8 command, communication and coordination structure. See Attachment 6 for details of this structure.

   2) For the purposes of coastal county evacuations that require assistance of state or federal resources the Department of State Health Services (DSHS) divides the State of Texas into two geographic divisions and utilizes two regional Medical Operation Centers (MOC) to provide enhanced command, coordination, and communication of medical activities. The CMOC in Houston is utilized in Division 1 and the RMOC in San Antonio in Division 2. Emergency Response officials in local communities are advised to contact the appropriate staff of these two MOCs to establish communication processes and discuss operational aspects related to a large-scale disaster.

      a) Division 1 (CMOC-Houston): Division 1 includes contiguous counties along the Texas coast that are located between the Sabine River in eastern Texas to the Matagorda County/Jackson County line at the northern end of the coastal bend.

Houston is the regional point for staging and evacuation support of this division of coastal counties. Designated as the regional staging area for Division 1, numerous resources and activities are conducted in Houston in support of coastal evacuations. TDEM and DSHS will utilize the designated staging location (site to be determined) to store medical supplies and equipment, and to stage medical assets including transportation vehicles and personnel.

The command and control of staging operations in Houston are coordinated at the DDC. All ESF-8 activities conducted by DSHS are coordinated through the DDC utilizing the following resources:

   i. DSHS Health Service Region 6/5S and Health Service Region 4/5N.

   ii. CMOC in Houston.

   iii. RMOC in San Antonio.

b) Division 2 (RMOC-San Antonio): Division 2 includes contiguous counties along the Texas coast that are located from the Matagorda County/Jackson County line to Brownsville at the lower end of the Rio Grande Valley. San Antonio is the regional point for staging and evacuation support for this division. Designated as the regional staging area for Division 2, numerous resources and activities are conducted in San Antonio in support of coastal evacuations. TDEM and DSHS will utilize the designated staging location in San Antonio to store medical supplies and equipment, and to stage medical assets including transportation vehicles and personnel.

The command and control of staging operations in San Antonio are under the DDC. All ESF-8 activities conducted by DSHS are coordinated through the DDC utilizing the following resources:

   i. DSHS HSR 8

   ii. RMOC San Antonio

   iii. Southwest Texas Regional Advisory Committee (STRAC)

     See ATTACHMENT 11 – Map Coastal Evacuation Counties for details breakdown.

b. Other supporting agencies, including the HSRs, RACs and local public health partners, are utilized to assist in gathering ESF-8 related information including: facility statuses, available hospital beds, End Stage Renal Disease (ESRD) facilities statuses, shelter usage reports, and other medical and public health related activities in their regions related to a large scale disaster

4. Procurement and Deployment of Assets

a. As has been mentioned, a large disaster can quickly overwhelm the capacity of most local emergency response systems and medical systems. The demand for medical transportation assets may rapidly deplete local resources which can trigger the need for additional medical support assets. Deployed RAT and MIST response teams will work with local and regional officials to establish a communication processes to:

1) Identify the assets needed to support the local response efforts

2) Develop the communication links that are necessary to properly coordinate the arrival and management of the medical transportation and medical care assets that are utilized during a large scale disaster response.

b. Requests for assistance can be done in hard copy utilizing the designated request forms, or electronically utilizing the appropriate WebEOC requesting "board". The recommended method is to utilize the electronic version of the State of Texas Assistance Request (STAR) that was developed and built into WebEOC. All requests MUST follow the prescribed state request process.

c. For details and/or questions on this process contact your regional emergency management coordinator, the TDEM District Coordinator, or your local WebEOC Administrator. Additional WebEOC support can be obtained by contacting the Texas WebEOC Interoperability Project (T.W.I.R.P.) at the following e-mail address: support@strac.org or by phone at 210-233-5888.

5. Initiation of Operational Response Activities for DSHS

a. Local emergency management officials have the responsibility to determine if they should evacuate OR shelter-in-place. If the officials determine they must evacuate and they need assistance utilizing state and federal resources then Section D. Evacuation Operations of this response operating guidelines will be utilized.

b. **The decision to Shelter-in-Place** – Local emergency management officials and the facility administrators should consider all aspects of their operations when deciding to "shelter-in-place". Facility administrators that decide to shelter-in-place must plan accordingly and have a 96 hour* supply of the following assets:

1) Staff to support on-going operations, including having a policy that addresses support of staffs' immediate family members

2) Generators and sufficient fuel to support emergency power needs, including some or all of the facility's HVAC systems

3) Security measures in place

4) Food and potable water

5) Medical supplies, including pharmaceuticals, dressings, disposable gloves, etc.

6) Linens

7) Emergency rooms operational

8) Utilities, including communication and waste water systems

9) Oxygen and other medical gases

10) Activation of existing mutual aid agreements, memorandums of understanding or contracts to augment staffing when sheltering-in-place.

Note: This 96 hour time frame is a Joint Commission on the Accreditation of Health Care Organizations (JCAHO) requirement. DSHS and TDEM recommended that any facility that opts to shelter-in-place should have at least a 5-day supply of the above listed assets. Recent experiences with hurricanes indicate that there can be a disruption to infrastructure including electricity and water supplies for up to 14 days.

D. EVACUATION OPERATIONS

1. TDEM and all Emergency Support Function (ESF) agencies will work together to assist any community requesting assistance to evacuate during a large scale disaster.

2. In general, **ground evacuation** is the first and primary mechanism of transportation that will be utilized during a large scale evacuation. Because of the difficulty of establishing and utilizing air transportation assets, every effort should be made to evacuate utilizing ground transportation as

the primary choice for evacuation. NDMS and TxMF air transportation assets will be utilized when ground transportation assets are unable to move the anticipated medical patient load.

3. **Any medical facility (hospital, nursing home, ESRD) that determines it will evacuate must notify the local EOC.** This notification is required even if the facility has resources available to complete a self-evacuation. This notification advises local authorities of the potential reduction in anticipated medical assets, including the loss of the facility AND the loss of other medical transportation assets.

4. If a facilities plan for self-evacuation fails, the facility manager, following locally established guidelines, shall make a request for assistance by notifying their local EOC. The local EOC/MOC will determine the course of action to take and execute that plan of action. The evacuation support may be accomplished solely with local medical transportation assets or a combination of local, regional and state assets.

5. If the local EOC requires additional support from the State they must request assistance, following the State request process. A state supported evacuation will have two distinct phases: Ground Evacuation, which is first and the primary means of evacuation; and Military Air Evacuation, which is utilized ONLY when ground transportation assets cannot meet the needs of the movement requests.

6. For either phase, the local government must submit a Patient Movement Request (PMR) to the State Medical Operation Center as outlined during the incident (Attachment 7).

   a. The DSHS SMOC will receive and evaluate the PMR and determine if state assets and/or federal assistance is necessary.

   b. All requests for additional federal assistance will be coordinated with the Global Patient Movement Requirements Center.(GPMRC) team to process the PMR into the National Disaster Medical System (NDMS).

   c. The SMOC Operations Section will then work with local, state and federal partners to coordinate and provide the necessary assets to the local community in support of their evacuation mission.

E. FACILITY EVACUATION

1. The local EOC is responsible for command and control of the evacuation process once a request for assistance has been made by a medical facility. The local Emergency Operations Center (EOC) will be supported by local response agencies (EMS, fire, and law enforcement) and the local Medical Operations Center – MOC.

2. DSHS Support Teams such as RAT, CAT, MIST, ASM, Triage Teams, Bus Teams, etc., will all work to support a facility and local community's evacuation efforts.

3. If the healthcare administrator makes the decision to begin evacuation of a healthcare facility the healthcare facilities responsibilities include:

   a. Activation of the facility emergency operations plan

   b. Notification to the local EOC/Medical Operations Center of the intent to evacuate:

   Utilizing the local procedures, provide the basic patient information (ex: information on the Patient Movement Request (PMR)form which indicates the hospital, patient numbers and acuity levels of patients that require medical transportation process) to their supporting EOC/MOC. The local EOC/MOC must have this information in order to identify the proper type and quantity of medical transportation assets required to evacuate the people with medical needs. If assistance is needed to identify and categorize persons they can request assistance to their EOC. Response personnel supporting the MOC from local public health,

Health Service Region and DSHS (such as MIST) can assist in providing support to an evacuating facility.

Note: If the local EOC/MOC does not have sufficient ground transport assets to move all medical patients and Air Operations must be requested, the designated Patient Movement Request (PMR) form should be filled out and processed through the communication chain (appropriate EOC and DDC-MOC) to the to the DSHS SMOC. The MIST can assist in the processing of the PMR request. The early processing of the PMR will allow DSHS, Texas Military Forces, and NDMS to develop the "Mission Assignments" for air operations.

c. If a facility does not have a receiving location for their medical clients being evacuated they must notify the EOC that they require assistance in this also.

d. Essential personnel and resources to respond to the evacuation operations

1) Evacuation Triage Teams - The mission of the personnel on the Triage Team is to integrate with local jurisdiction triage personnel and assist with the triage of medical patients for appropriate transportation needs and sheltering placement.

2) Facility Evacuation Team – staff and assets utilized to coordinate the movement of patients within a healthcare facility to a sister facility, non-affiliated facility or transportation hubs. They determine which people to evacuate and prepare them for the transfer to the transportation asset.

3) Facility Patient Load Officer – staff responsible for triaging individuals and validating the number of patients requiring transportation and the level of transport assistance that is needed. They coordinate with the local Emergency Operation Center (EOC).

4) Facility Triage Point – a location at the healthcare facility where the Facility Load Officer and the Ambulance Strike Team Leader coordinate the order and sequence in which triaged patients are loaded onto medical transportation assets.

e. Provide the name(s) of medical support staff that will travel with the patient and assist in providing medical care during transport.

f. The facility personnel (Facility Patient Load Officer and the Facility Evacuation Team) will follow their established protocols in order to execute a safe and efficient evacuation of the patients.

4. Hospitals that have contracted for private air and ground ambulance assets and can execute their plan without state or federal assistance will use the designated airport identified in their respective plans. Hospitals utilizing these private contract operations will not use any designated state or federal established Air Hubs for their evacuation operations.

F. AMBULANCE UTILIZATION

Experience with major catastrophes has shown that, during any large scale disaster, there is a very finite supply of medical transportation assets. Therefore it is critical that these assets be properly managed and utilized throughout a response to an event. DSHS has developed specific criteria on how medical transportation assets will be utilized during a catastrophic emergency. The information can be found in the **Response Operation Guideline – Ambulance Utilization 2012.**

G. TRIAGE FOR TRANSPORTATION

1. People with medical needs will be transported on any of the following types of transportation asset:

a. Ground assets

1) Ambulance or Ambus

2) Litter Bus (medical conversion bus)

3) Specialty Ambulance (i.e.: Bariatric capable, pediatric capable)

   (Note: these assets are in very limited supply)

4) Medical Bus ("Coach" style bus with medical staff and equipment only)

5) Para transit – for mobility challenged people.

b. Air assets

1) Rotor wing Ambulance (helicopter)

2) Fixed wing-plane (small-private and some FEMA)

3) Specialty air transport (i.e.: neonatal, ICU capable, etc.)

4) Military Air Assets (TxMF and NDMS)

2. Triage

In a large-scale emergency evacuation, the demand for ground and air transportation assets is extremely high and these resources, if available, are limited. Medical triage is conducted to make sure the patient is placed on the most compatible and appropriate transportation asset based on their specific condition and needs. The decision as to what type of medical transportation asset a person with medical needs will be transported on is determined by medical guidance and availability of the prescribed assets. The triage assessment will occur at the medical facility, ground embarkation points, and Air Hubs. It is highly probable that a person with medical needs will be assessed and triaged more than one time in order to make sure the person is placed on the correct transportation asset. The goal of triage is to make sure the person is on the most compatible mode of transportation available and that the patient is healthy enough to survive the movement during the evacuation.

3. The Texas Department of State Health Services has worked with our response partners and developed several documents that will assist in the "Triage" process. These documents are found under the following attachments:

a. Attachment 13 Air & Ground Ambulance Utilization Criteria

b. Attachment 14 TxMF - Aero-Medical Evacuation of Inpatients in a Disaster

c. Attachment 15 NDMS - Absolute Contraindications for Flight

4. For further information see "Response Operating Guideline - Ambulance Utilization 2012.

H. MEDICAL EVACUATION – GROUND TRANSPORTATION

1. The evacuation of medical patients during a large scale disaster will **always start** with ground transportation assets. The determination as to what type of medical transportation asset a person with medical needs will be transported on is determined by medical guidance and availability of the prescribed assets (See "Triage For Transportation" above). In a large-scale emergency evacuation, the demand for air and ground transportation assets is extremely high and the supply is limited. This fact may alter established protocols for medical transportation under normal circumstances.

2. The following information describes the various characteristics and processes of the ground evacuation:

a. Transfer Types

1) Patients may be transported from an evacuating facility to an awaiting facility in a *facility-to-facility* transfer

2) Patients may be transported from the evacuating facility to a reception point in a receiving community Reception Center or Staging Area, where they will be triaged and

transferred to an appropriate medical facility, assisted living facility, or medical shelter. Local jurisdictions will establish these reception centers and staging areas and make the determinations as to what type of facility the person will be transported to.

3) Patients may be transferred from an evacuation Embarkation Point on a state medical ground transportation asset, and then to a receiving community's Reception Center where they will be triaged, and transferred to an appropriate medical facility, assisted living facility, or medical shelter. Local jurisdictions will establish these reception centers and staging areas and make the determinations as to what type of facility the person will be transported to.

b. Ground Transportation Assets Sources

1) **Local** medical transportation resources (both private and municipal) will be supplied from the local EMS system and/or private contractors until this resource is exhausted or unable to support the evacuation mission.

2) **Regional** medical transportation assets will be requested by the EOC through activation of their mutual aid agreements with surrounding jurisdictions and through the local region's Multi Agency Coordination Center (MACC).

3) **State and/or federal** medical transportation assets (ambulances, ambulettes, Ambulance Buses, medical Coach Buses, converted School Buses, etc.) will be requested by the EOC/MOC to the appropriate DDC/DMOC.

   a) The regional DDC will make a request to the SOC and, *once approved and procured*, the assets will be deployed to the requesting DDC region from the State Staging Area (based in the San Antonio State Staging Area).

   b) Once deployed to a designated DDC's Region's Staging Area, these assets and will be under the command of the region's DDC/DMOC.

c. Regional Emergency Medical Task Force (EMTF)

1) Regional EMTF

   a) There eight regional Emergency Medical Task Forces (EMTF) in Texas. Each is geographically located to match the DSHS Health Service Regions.

   b) Each regional EMTF has four distinct operational components:

      i. Ambulance Strike Teams (AST) - Each EMTF has five AST consisting of five ambulances and an Ambulance Strike Team Leader that can be deployed regionally or on a statewide mission.

      ii. Ambus Strike Team - two fully staffed multi patient vehicles (MPV) that can be deployed to an incident locally, regionally, or on a state mission.

      iii. Registered Nurse Strike Teams (RNST) - groups of specialized Nurses that may be deployed to provide medical care to stressed medical facilities which has been overwhelmed.

      iv. Mobile Medical Unit (MMU) - the most complex component of the EMTF, the MMU is essentially a deployable Emergency Room. The MMU is comprised of physicians, nurses, and paramedics with appropriate tentage and life-saving equipment to provide emergency care and stabilization capabilities in austere environments.

2) EMTF Deployment

   a) The four separate components of the EMTF are available as a local response, regional response or a state level response.

b) Each component can be requested as a single component, as a partial EMTF response with a specified combination of EMTF components, or as a full EMTF response with all four components.

c) Each component can be scaled in scope, size and mission assignment to fit the incident.

3) Requesting EMTF support

a) For a local response to an incident (any response within the geographic region of the EMTF) the local emergency management coordinator will make the request to the regional EMTF Coordinator.

b) For a state level request (a request outside of the EMTF's assigned geographic region) the request MUST follow the established state process and be made through the DDC up to the SOC. TDEM and DSHS will review the request (in WebEOC it is called a "State of Texas Assistance Request", or STAR) and upon approval, procure and deploy the requested EMTF medical assets.

d. Ground Transportation Asset Locations

1) State Staging Area – Primary: The initial State Staging Area for State medical assets is in San Antonio at the Alamo Regional Command State Staging Area.

a) DSHS, HSR-8 and the San Antonio RMOC response personnel provide overall management of the medical transportation assets staged at the San Antonio Staging area.

b) Requests for these assets follow the established state requesting procedures. All medical assets deployed from the State Staging Areas will be approved by TDEM/SMOC.

2) State Staging Area – Secondary: A secondary State Staging Area may be established in the Houston Region.

a) DSHS, HSR-6/5, CMOC and MIST response personnel provide overall management of the medical transportation assets staged at the San Antonio Staging area.

b) Requests for these assets follow the established state requesting procedures. All medical assets deployed from the State Staging Areas will be approved by TDEM/SMOC.

3) District Staging Area - the Forward Staging Areas

a) The District Staging area is located in or near the impacted region or evacuating region at a location established by the requesting DDC. Note: there may be more than one of DDC District Staging Area.

b) Medical assets in State Staging will be deployed into the District Staging Area based on the disaster event and assistance requests made by the DDC regions.

c) The requesting DDC must anticipate and plan for logistic support for these assets.

d) Ambulance Staging Managers - DSHS MIST and Ambulance Staging Managers will assist in:

i. Identifying a proper location for a District Staging Area.

ii. Provide oversight and management of deployed medical transportation assets

iii. Support for the District Staging Area and assist in requesting logistical support through the regional DDC.

e. Requests for Ground Transportation

   1) Requests for medical ground transportation assets (ambulances, medical buses, et al) follow the State of Texas designated request path. This process must be followed whether a jurisdiction uses the WebEOC "State of Texas Assistance Request" (STAR), or they use a hard copy of a request for assistance processed to their DDC. All requests for medical transportation assets will be made from the local EOC-MOC up to and through to the DDC/DMOC.

   2) Ambulance assignments will be coordinated through the District Medical Operation Center supporting the DDC. The medical professionals coordinating ESF-8 activities (HSR, MIST, EMS officials, et al) within the DMOC will provide oversight in the deployments of Ambulance Strike Teams and other medical transportation assets within the DDC region.

   3) "Mission Assignment" - Medical transportation assets will be deployed from the designated District Staging Area to a specified "mission assignment". Approved mission assignments include:

      a) A facility evacuation – facility to facility patient movements.

      b) A facility evacuation – facility to reception point or specified evacuation shelter.

      c) Support to an Embarkation Point for transporting patients to a designated reception point or shelter.

      d) Air Hub support as part of the Air Hub Ambulance Transportation Team (AHATT)

      e) Other mission assignments as determined by the DDC District Medical Operation Center (DMOC).

   4) For further details see the Response Operation Guideline – Ambulance Utilization 2012.

I. **MILITARY AIR EVACUATION – INTRODUCTION**

1. During a disaster in Texas, the evacuation of a community's medical needs population begins with ground transportation assets (Ambulances, Ambuses, Medical Buses, Litter Buses, etc.). Studies of the coastal regions medical population have indicated that the ground transportation assets may be inadequate to meet the transportation needs for the medical population. Thus, the military air resources of Texas Military Forces and/or the National Disaster Medical System (NDMS) may be needed to provide additional evacuation capability.

2. A Military Air Evacuation is one of the most complex operational processes that emergency response personnel will ever be involved in. Multiple agencies (public and private) and several layers of government are involved and they must work together in order to achieve success. The following section "Aeromedical Evacuation Utilizing Military Air Assets" describes the various aspects of a Military Air Evacuation and it outlines the responsibilities of the local, State and federal response partners that will come together during these operations.

3. Utilization of TxMF and/or NDMS Military Air assets for evacuation is not an automatic endeavor. In order for Texas Military Forces and/or NDMS to provide evacuation support utilizing the large Military planes several prerequisite events MUST occur, including:

   a. Local and state response personnel determine that ground transportation efforts cannot meet the needs of their medical evacuation.

   b. There must be a "State Disaster Declaration" to utilize Texas Military Forces assets

   c. There must be a "Federal Disaster Declaration" to utilize NDMS assets

   d. Texas Military Forces and NDMS must have deployable assets available

e. There must be sufficient time to enable these supporting agencies to respond effectively

J. AEROMEDICAL EVACUATION UTILIZING MILITARY AIR ASSETS

1. Transfer Types

   State and federal support for Military Air Operations during a large scale evacuation fall into a few types of patient movement:

   a. Movement of non-medical civilians utilizing contracted civilian aircraft and military aircraft (*note: this activity is not addressed in this document*).

   b. Movement of medical patients utilizing contracted small fixed wing aircraft and/or rotor wing medical helicopters, sometimes referred to as Air Ambulances (i.e.: private ambulance carriers and federally contracted assets)

   c. DSHS contracts with private providers for this asset

   d. NDMS deploys small air assets (rotor wing and fixed wing) that support the deployed NDMS ground transportation assets (Ambulances and para transit vehicles).

   e. Movement of medical patients utilizing the large military aircraft and medical support teams provided by Texas Military Forces and/or the NDMS.

2. Air Hub Types – Military Air Assets

   a. Texas Military Forces Air Hub- State operations in which patients are flown from an Air Hub to a receiving airport in a designated city. From there they are medically triaged and transferred to an appropriate hospital, nursing home, or medical shelter.

      1) The Air Hub is established by Texas Military Forces

      2) Local jurisdictions provide logistic support to Texas Military Forces operations at the Air Hubs and Reception Centers

      3) DSHS supports these Air Hubs based on information from pre-incident surveys.

   b. NDMS Air Hub – a federal operation in which patients are flown from the Air Hub to a receiving FCC.   From there they are medically triaged and transferred to an appropriate hospital, nursing home, or medical shelter

      1) The Air Hub is established by NDMS

      2) When NDMS is activated Texas Military Forces will fold into the NDMS operational process. At this point ALL large air assets will become federal assets under Title 10

      3) Local jurisdictions establish and provide logistic support to Texas Military Forces operations at the Air Hubs and Reception Centers

      4) DSHS will support these airports in issues related to ESF-8 efforts based on information from pre-incident surveys

   c. Federal Coordinating Center (FCC) is a designated airport that is able to receive NDMS patients. There are several in Texas (see map below)

Army
Navy
Air Force
VA
Hawaii
Puerto Rico
EP
DFW
SA
H
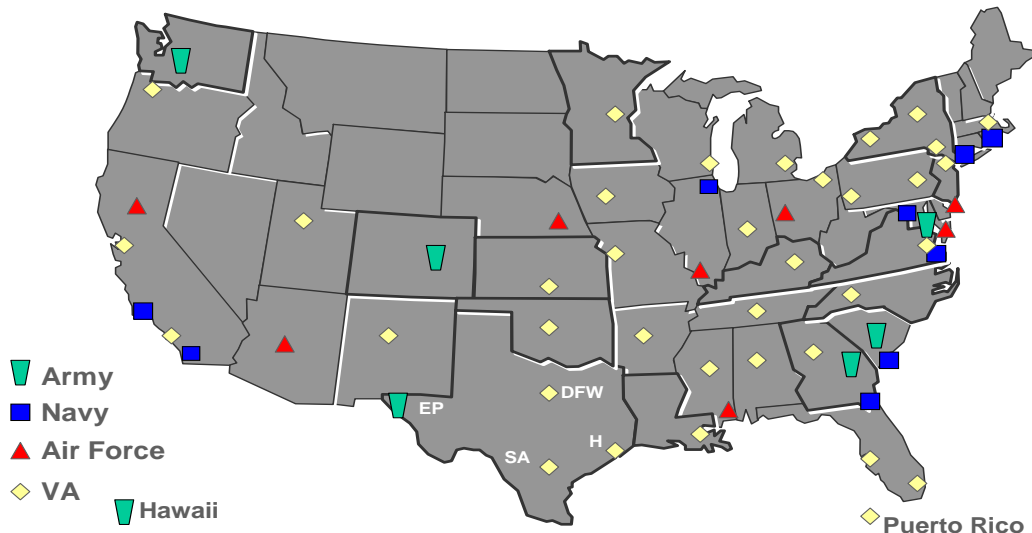
1) Texas Emergency Management has already determined that only two of the FCC's in Texas will be utilized for a coastal evacuation

2) Dallas - Primary FFC and first utilized during and NDMS Evacuation

3) El Paso – Secondary FCC and utilized when the Dallas FCC can no longer process incoming medical patients.

3. Air Transportation Assets Sources

In a disaster air assets are obtained from the following sources:

a. "Small Air" assets (fixed wing and rotor wing) from:

1) Hospital contracted - private Air Ambulance companies

2) DSHS contracted - private Air Ambulance companies

3) FEMA contracted as part of the support package for ground ambulances

b. Military Air assets –Texas Military Forces

1) Acquired through a submittal of an agency-to-agency STAR.

2) The STAR will only be submitted when DSHS, TDEM and Texas Military Forces agree that the need for local support warrants the activation of these Large Air assets AND there is sufficient time to establish an effective Air Hub.

c. Military Air assets – NDMS

1) Acquired through a federal Action Request Form (ARF) submitted by DSHS and TDEM

2) The ARF will only be submitted when the State and federal partners agree that the need for local support warrants the activation of these assets AND there is sufficient time to establish an effective Air Hub.

4. Air Transportation Asset Locations

Air assets (Small and Large) are located at their home base airports until they are contracted into a response. At that point they are provided a "Mission Assignment" and they report to the designated patient pick up location, be it a hospital, airport or Air Hub.

5. Mission Assignments

Air assets are deployed from their home base of operation to a designated location based on their "mission assignment".

a. Small Air assets are deployed to a specified hospital (for rotor wing) or an airport (for small fixed wing) as outlined in their "Mission Assignment

b. Large Air Assets are deployed to a designated Air Hub as outlined in their "Mission Assignment".

K. REQUESTS FOR SUPPORT – MILITARY AIR TRANSPORTATION

If a disaster (or pending disaster) is significant enough to justify the need for a large scale evacuation of a region's medical population, and ground transportation assets cannot meet that need, then the State of Texas may request for additional evacuation support from Texas Military Forces and the National Disaster Medical System (NDMS). For this request to be made the following must happen:

1. There must be a state and/or federal Disaster Declaration. The Texas Military Forces and NDMS cannot activate without these declarations.

2. The available local, state and federal medical ground transportation assets and small air transportation assets cannot adequately support all patient transportation requests.

3. There must be a Patient Movement Request (PMR) asking for additional evacuation support from the regional DDC/DMOC. This is an "Official" request by the region to move medical patients utilizing the military air transportation assets of the Texas Military Forces and/or NDMS.

4. The request is made with sufficient time available to allow these two supporting agencies to respond and initiate a successful support operation.

L. PATIENT MOVEMENT REQUEST FORM (PMR) AND "PATIENT-MISSION MANIFEST"

For Texas Military Forces and NDMS to properly process any requests for a medical evacuation utilizing their military air transportation assets they must first receive the patient information that is found on the "Patient Movement Request" form. The "Patient Movement Request" is a form utilized by the NDMS system that captures critical patient information that is provided to the NDMS response personnel. The form captures basic facility and patient information (name, age, sex, acuity, TexasETN number, etc.). This information enables Texas Military Forces and NDMS to procure and deploy the most appropriate medical support personal and equipment.

The PMR is initiated as follows:

1. Hospitals and Nursing Homes should report their status to their Emergency Operation Center/ Medical Operations Center (EOC/MOC) as requested by their local emergency management officials. This applies if they will shelter-in-place, evacuate on their own without assistance, or evacuate and require assistance. They should provide their facilities status to the EOC/MOC in the format prescribed by their local emergency management.

2. If the local EOC/MOC determines that ground evacuation efforts will not meet the medical evacuation requests and they must request additional state and/or federal military air assets to support their evacuation, then the "Patient Movement Request" form must be submitted.

3. Submittal of the PMR to the EOC/MOC and the DDC/MOC

a. Either the evacuating hospital or the local EOC/MOC must enter the patient information into the PMR form or into the proper section of the WebEOC Board TexasETN Board.

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b. The Patient Movement Request (PMR) is then sent to the local EOC/MOC by fax or e-mail, or through the WebEOC ETN Board.

c. When the EOC/MOC receives the PMR the medical personnel will:

   1) Check the PMR for completeness

   2) Review the PMR and assess the patient acuity information and determine if any patients are not viable for military air evacuation (i.e.: no contra-indications to flight).

   3) Those patients not viable for military air evacuation will be:

      a) evacuated by ground assets or

      b) sheltered in place or

      c) transferred to other hardened facility

   4) Those patients that have no "contra-indications to flight" will be left on the PMR and forwarded to the appropriate Division Medical Operation Center (DMOC).

d. The medical support teams in the DMOC (the hospital reps, MIST, HSR personnel, RAC personnel, et al) will further vet the information and determine which patients can be moved or not moved by ground and air assets.

4. Submittal of the Patient Movement Request to the SMOC

a. The medical staff in the DMOC should review the PMR and make sure that the patients listed are eligible for a military air transportation (i.e.: no contra-indications to flight)

b. The PMR listing the patients that are going to be air evacuated from a region (utilizing TxMF or NDMS military air assets) are sent from the DMOC to to the State Medical Operation Center (SMOC) as follows:

   1) Hard copy - PMR can be submitted to the SMOC as follows:

      a) e-mailed to: dshsoperations@dshs.state.tx.us or

      b) Faxed to 512-532-4980 (coordinate this FAX with a phone call to the SMOC Operations Branch to advise that a "PMR" has been sent. SMOC Phone # is: 512-532-4950.)

      c) Submittal of the PMR should follow the process described in Attachment 7- Patient Movement Request Form – PMR – 14 STEP FLOW PROCESS.

   2) WebEOC Texas ETN Board:

      a) Check the appropriate sections in the WebEOC ETN board that will forward the PMR request to the DSHS SMOC. (The DMOC MIST representative should coordinate this PMR submittal with a phone call to the SMOC Operations Branch to advise that a "PMR" has been sent utilizing WebEOC. SMOC Phone # is: 512-532-4950.)

      b) DSHS will respond to the WebEOC ETN Board patient movement requests as if it had received the Official PMR in hard copy.

      c) The information in WebEOC will be transferred to a hard copy PMR form and submitted to the NDMS GPMRC representatives in the SMOC.

      d) The SMOC staff, working with the GPMRC personnel on the SMOC, will process the PMR and build a "Patient-Mission Manifest". Submittal of a WebEOC Patient Movement Request should follow the process described in Attachment 7- Patient Movement Request Form – PMR – 14 STEP FLOW PROCESS.

e) After the PMR's has been processed the GPMRC will build the "Patient-Mission Manifest" and this information will be forwarded back to the regional DMOC and the local EOC/MOC and evacuating facilities by reversing the established points of contact.

M. TEXAS MILITARY FORCES AND NDMS AIR EVACUATION

1. Aeromedical Evacuation (AE) operations are provided by the resources and personnel from the Texas Military Forces (state) and/or the National Disaster Medical System - NDMS (federal). Note: Medical professionals and emergency management leaders need to understand that the flight on a military type aircraft (C-17 and C-130) is very harsh to a MEDICAL POPULATION person. A community should view NDMS and Texas Military Forces Military Air Evacuation operations as a "last resort" step in their evacuation process. Military type air assets are utilized primarily because all other efforts and systems in place have not met the demand for evacuation capacity.

2. Because a state disaster declaration usually is given before a Presidential disaster declaration, Texas Military Forces (state) Military Air Evacuation operations usually are initiated before Federal NDMS operations. Once a Presidential disaster declaration is received then federal air assets can be activated and NDMS military air operations may be initiated. Both NDMS and TxMF operations can function simultaneously at an Air Hub.

3. For both state and federal military air operations, people with medical needs are received at the Aeromedical Marshaling Point (AMP) at a designated Air Hub where they are processed, triaged, prepared and made "flight-ready", transferred to an aircraft, and evacuated to receiving location. Any patient that cannot be made "flight-ready" will be transported to an acceptable facility with shelter-in-place capability OR evacuated by ground asset, or other appropriate air asset. At the receiving sites (For NDMS flights they will be transported to a Federal Coordinating Centers - FCC), the people with medical needs are "triaged", provide necessary medical care, and then transported to an appropriate medical facility based on their current medical conditions.

4. Whether a person is evacuated on a state air asset by Texas Military Forces (a non-NDMS evacuee) or a federal asset by NDMS (an "official" NDMS evacuee) the PMR and the "Patient-Mission Manifest" shall be utilized to coordinate and document all air evacuee transfers.

N. COMMAND AND CONTROL OF AIR HUB OPERATIONS

The State Operating Center and the SMOC will closely monitor a storm's path and the potential impact to a region. If Military Air Evacuation operations are anticipated Texas Military Forces and NDMS will be notified and assets will be "pre-stage" at designated Air Hubs in anticipation of the air evacuation. The following is a general overview of how these Air Hubs will function:

1. Command and Control

   a. Air Hub operations are performed under a Unified Command System.

   b. **Local jurisdictions are requested to provide the Incident Commander.**

   c. A state "Incident Management Team" (IMT) can be requested to assist in overall coordination of Air Hub operations.

2. Patient care at the Air Hubs will be provided by some or all of the following medical response partners:

   a. Local medical providers from local medical response teams and EMS

   b. Emergency Medical Task Forces (EMTF) with some capabilities of support including:

      1) MMU medical response personnel

2) MMU tent structures

3) State medical teams

c. Mobile Medical Teams – medical teams procured and deployed by DSHS

d. Texas Military Forces medical response teams (obtained through EMAC)

e. NDMS medical support teams (MASF/DMAT Strike Team) can provide limited patient care if an Aeromedical Marshaling Points (AMP) is located at the designated Air Hub. The primary objective of the MASF is to package patients and make them "air ready" prior to the patients being loaded on the designated aircraft. Note – the DMAT Strike Team's primary role is to provide workforce protection for the air operations crew and is not specifically assigned to patient care element.

3. Patient Care on the Military Air Evacuation asset will be provided by:

a. Texas Military Forces will provide medical support teams for their air assets.

b. NDMS - The Aeromedical Evacuation (AE) crewmembers

Note: One hospital staff member or family member can travel with patients on NDMS flights, but may not provide in-flight medical care. This request to accompany the patient must be noted on PMR.

4. If requested and available, DoD can assign a Critical Care Air Transport Team (CCATT) to manage those patients needing critical care support.

a) The movement of a critical patient reduces the available patient load capability on a military aircraft

b) Each CCATT is comprised of an intensivist, a critical care nurse and a respiratory technician

c) One CCATT can manage 6 critical patients

d) There are VERY limited numbers of CCATTs, which limits the number of critical patients NDMS can be moved utilizing DoD aircraft

O. RECOMMENDED PATIENTS

1. In general, NDMS aircraft or Texas Military Forces aircraft should be utilized for the evacuation of community-based, low acuity medical citizens.   Even though NDMS has Critical Care Air Transport Teams (CCATT) that provide the capability to move critical care patients – those patients who are electrically or ventilator dependent or require intensive care – the process ties up significant medical resources which can impact the final outcome of the number of people that can be transported.

2. In order to maximize the capability of DOD aircraft and transport the greatest number of medical patients it is recommended that critical care patients be evacuated by ground or small fixed wing and rotor-wing assets.

3. Following this guideline maximizes patient throughput and ensures the appropriate standard of care is maintained.

4. Federal NDSM & TxMF Transfer activities:

a. Air operations from a designated Air Hub will be managed in a Unified Command ICS format under the authority of local emergency management and the airport manager and supported by NDMS and Texas Military Forces staff.

b. The Air Hub Unified Command will assure that:

1) All air transportation assets are assembled and ready to begin transportation of patients utilizing air assets.

2) The PMR submitted by the facility has been processed through the established steps and the evacuation "Patient-Mission Manifest" has been published (Shared with the appropriate EOC/MOC and medical facility evacuation team).

3) *Note: The "Patient-Mission Manifest" identifies the aircraft tail number, arrival time, and patients to be loaded on each aircraft. This helps determine the time when these patients should be transferred from a healthcare facility to the AMP.*

4) NDMS assets are located at the Air Hub and the Global Patient Movement Requirements Center (GPMRC) has processed the PMR and provided the "Patient-Mission Manifest" for NDMS assets to begin patient transfers.

5) Texas Military Forces assets are located at the designated Air Hub and have been provided a "Patient-Mission Manifest" of Medical patients that require Texas Military Forces air medical transportation assets.

6) Other rotor wing and fixed wing transportation assets have been assembled and are prepared to begin transfer of patients to designated facilities or reception points and these transfers are coordinated through the local EOCs of the evacuating and receiving facilities.

c. **Movement of Patients to the Air Hubs (Aeromedical Evacuation Hub-AE)**

1) The movement of patients from a medical facility to an Air Hub must be precisely timed to match the arrival of an arriving military air craft. Communications links between the Air Hub military personnel (NDMS and Texas Military Forces), the local EOC/MOC, and the evacuating Medical Facility must be well coordinated. The Medical Incident Support Teams (MIST) and the medical professionals supporting the ESF-8 response will assist in coordination of this process.

2) *Arrival Time* – Two (2) Hours prior to the designated planes arrival

   Transporting patients and having them arrive two hours prior to the planes arrival gives the Air Hub operations teams the necessary time to: receive, record patient arrival (WebEOC and JPAT), triage, prepare/package, and load patients onto the aircraft. Arrive too early and the patient waits, arrive too late and the planes wait.

   a) The movement control teams including local EMS and the Air Hub Ambulance Transportation Teams (AHATT) begin the movement of patients to the Air Hubs at the designated times provided by NDMS or Texas Military Forces as outlined in the "mission assignments".

      i.   MIST personnel will assist in coordinating this timing sequence

      ii. Ambulance Strike Leaders will coordinate with medical facility staff to move patients from the facilities to the ambulances as smoothly as possible.

   b) Ambulance Strike Team leaders shall notify the DMOC and the Air Hubs when they begin the movement of patients to the Air Hubs.

   c) MIST personnel at the Air Hubs shall notify the DMOC of arrival of ambulances and assist in recording the patient's arrival in WebEOC.

   d) The physical efforts to move large numbers of patients off of an ambulance, around the medical staging area for triage and packaging, and onto the air asset requires a significant amount of personnel. Note: Local jurisdictions should plan for a process of calling in previously identified teams of personnel to assist in the performance of this task.

P. EMBARKATION ARRIVAL AND OFFLOAD

Key Components to the Air Hub (Aeromedical Evacuation Hub-AE)

There are several distinct operations that transpire at an Air Hub. The following is a brief description and purpose of the various components.

1. AE Command Squadron – The AE Command Squadron provides Command and Control of assigned AE forces. A small team of up to 8 personnel that provide the "eyes on ground" for TxMF and/or NDMS. They can request airplanes arrive faster slower, request more support, work priorities of mission needs, etc. The AE Command Squadron is usually the first military representative at the Air Hub. They will advise the appropriate personnel/agencies on Air Hub concept of Operations, capabilities, and requirements. They provides procedural, technical guidance and management of the Air Hub.

2. Liaison Teams- also called the Aeromedical Evacuation Liaison Team (AELT) by the military. These teams build the communication links and provide the transfer of critical information to all the various support agencies that are part of the Air Hub Operations efforts. The Liaison Teams provide a direct communications link and immediate coordination between medical facilities, EMS, EOC/MOC, DDC/DMO, Air Hubs and receiving locations. The Liaison Teams can assist in determining if a patient is flight worthy, needs a CCATT team, etc. They are advocates for the patient and the hospital as they assist in connecting into the Military Aeromedical Evacuation system.

   a. Direct communications link into AE system

   b. Verifies flight physiology issues and movement requirements

   c. Communicates airplane/mission times

   d. May use numerous communication methods

   e. Assists Tracking (patients to missions and destination)

3. MASF – Mobile Aeromedical Staging Facility – This is the most visible component of an Air Hub. The MASF is a mobile temporary staging facility deployed to provide supportive casualty nursing care and administration. No Flight Surgeons are assigned to the MASF. The MASF provides rapid response patient staging, limited holding and Aeromedical Evacuation (AE) crew support capability. The MASF includes the capability to receive patients, provide supportive patient care, and meet administrative requirements on the ground while awaiting Aeromedical Evacuation.

   The length of time a patient stays in the MASF is intended to be just enough to get the patient ready and safe for flight. Ideally this would be about 2 hours. Maximum throughput can only be achieved with support from litter teams and local EMS to provide manpower and vehicular support for patient movement.

4. Liter Teams-Local emergency management officials should make preparations to provide "litter bearers" to support the movement of patients on and around the Air Hub and on to the air assets. This is a very labor intensive process and strong physically fit persons are needed for this task.

5. AE Flight Crews –. Aeromedical Flight crews provide the medical care and support during the evacuation flight and transfer of the patient to the receiving location (FCC for NDMS flights). The typical flight crew has the capability to provide advanced care life support (ACLS). More critical patient requires a Critical Care Aeromedical Transportation Team (CCATT). In order to optimize the numbers of patients that can be moved it is highly stressed that most military evacuations not involve critical patients.

6. Texas Military Forces - From the perspective of the local response personnel, the catalysts and processes to activate TxMF and NDMS are similar in nature. If it is determined that the use of military air assets will be utilized to evacuate medical patients it is highly probable that Texas Military Forces will establish the initial Air Hub. One difference is that the Texas Military Forces will evacuate patients to designated locations based on the incident. This may bring in a receiving airfield other than Dallas/Ft. Worth or El Paso.

The receiving airports must be prepared to provide medical assistance to:

a. Off load patients.

b. Triage patients.

c. Transport patients to receiving facilities.

7. NDMS – NDMS will only transport medical patients to their FCC site.

a. If a disaster strikes Texas and military assets are used for an evacuation, NDMS will evacuate patients to two primary FCC locations:

1) Dallas/Ft. Worth, primary

2) El Paso, secondary

b. The FCC Coordinator will ensure that the patient reception area and the Patient Reception Team are ready to receive the aircraft and patients.

c. The FCC will coordinate patient transportation from the debarkation airport to the designated NDMS participating hospitals through the local EOC/MOC.

d. The FCCs will track patients from the time they are received at the airport until they are discharged from a healthcare facility in accordance with NDMS guidelines in their JPATS system.

Visual Representation of AE
Patient Reception and Processing

1. Patients arrive and NDMS patients are identified by destination
2. Security directs vehicles
3. Transfer from gurney to litter and anti-hijacking and triage by mission
4. Hold area – provides minimal care
5. Configure arriving aircraft and load patients to appropriate mission
6. Mission launch.

Q. PATIENT TRACKING

Patient tracking will be coordinated between embarkation points, medical facility, embarkation sites and Air Hubs and debarkation points (hospitals, general population shelters, medical shelters, and long term care facilities) utilizing the state designated tracking system. The following tracking systems are utilized:

1. State "Texas Emergency Tracking Network"- (Texas ETN). This is the States of Texas designated medical patient and evacuee tracking tool.

2. WebEOC – Available in most regions across the state. Contact your local Emergency Management Coordinator or your WebEOC Administrator for access into the WebEOC system in your region.

3. EMSystems- EMTrack – utilized in the Houston, Panhandle and Lower Rio Grande Valley.

4. Beaumont Tracking System

   Note: During an NDMS military Aeromedical Evacuation patients will be tracked in the NDMS JPATS system by DoD and in the Texas ETN system by Texas response personnel.

VI. MAINTENANCE & UPDATE

The Response and Recovery Unit is responsible for maintaining and updating the DSHS Response Operating Guidelines. These are living documents and will be reviewed, updated, and approved on an annual basis or more frequently in response to department policy or procedure changes. Revisions/changes made to the ROG after the Effective Date (May 1) are recorded in the Record of Changes form found on Page 3. Below is the review and update schedule that will be followed:

March – April	Review and Comment
May 1	Effective Date

VII. ATTACHMENTS

ATTACHMENT 1 – H-120 TIMELINE

H-Hour	Activity	Responsibility
H-120	Activate "Call Down" for DSHS Command staff and initial SMOC Teams	DSHS Response and Recovery Unit
	Texas - Notify EMS Ambulance MOA providers of pending situation to confirm availability of EMS assets.	DSHS
	Federal – Advise Contractors and FEMA Acquisition, advise ambulance contractors on status.	HHS
	Identify resource needs and communicate with SOC via an **Action Request Form (ARF)** regarding: • Disaster Medical Assistance Team • Disaster Mortuary Teams • Medical Transportation Support –Ambulances and Para Transport, NDMS, et al Provide information to Texas State Operation Center (SOC)	DSHS Operations and Incident Director
	Potential Emergency Management Assistance Compact (EMAC) requests are verified and core language drafted.	DSHS
	Establish state ESF-8 conference call schedule: • SOC • HSR • Division 1 and/or 2 and RAC/MOC	SOC & DSHS
	Alert Regional Advisory Councils (RACs) to contact hospitals (Mental Health and Healthcare) to begin 12-hour reporting cycle of Hospital Available Beds in an Emergency or Disaster (HAvBED) data into the DSHS WebEOC TSA Medical Dashboard.	DSHS, RACs and Hospitals
	Contact RACs to notify medical facility regarding their intended response to the developing emergency based on projected storm intensity: • Shelter-in-place (SIP) – provide SIP form • Evacuation (partial or full) – provide all PMR for report of potential ground and air medical transportation support	DSHS, RACs, and hospitals
	Alert and check status of End Stage Renal Disease (ESRD) network	DSHS/DADS
	RAT placed on alert for possible deployment.	DSHS & HSR
	MIST place on alert for possible deployment.	DSHS
	Validate medical supplies- jump bags and AED monitors- for ALS buses.	DSHS
	ALS Bus transportation Assist team alerted for deployment to San Antonio Staging.	DSHS
	Ambulance (Federal and state) & Bus Contractors (state) On Alert	DSHS and Federal IRCT Incident Response Coordination Team - HHS

H-Hour	Activity	Responsibility
H-96	• Seek state Declaration • Submit all MIEP Action Request Forms (ARFs)	SOC & DSHS
	Warning Order (Alert) issued for all AMPs (Federal -Aeromedical Marshaling Points or AMPs).	Federal IRCT Incident Response Coordination Team – HHS
	Initiate request for Federal Emergency Management Agency (FEMA) and Emergency Management Assistance Compact (EMAC) ambulances.	DSHS and SOC
	Begin to execute state MOA contracts for ambulances, personnel and supplies. Medical Transportation assets to report to San Antonio ARCC Staging (Division 2).	DSHS (Regulatory)
	Notify and activate designated Medical Incident Support Teams (MIST) for deployment. Teams report to San Antonio ARCC Staging (Division 2).	DSHS
	Notify and activate designated RAT for deployment to designated location as part of the state Forward Coordinating Element.	DSHS
	After mission briefing deploy MIST teams into evacuating region to liaison with evacuation region DDC/DMOC • Establish the "ESF-8 Incident Support Team". • ESF-8 Incident Support Team develops coordination and communication processes for evacuation of people with medical needs.	MIST Team, Evacuation MOC, Division MOC, DSHS
	Prepare to activate EMTF assets: nurses, EMTs and Paramedics for evacuation buses. Report to San Antonio ARCC Staging (Division 2).	DSHS (SMOC Logistics and Regulatory)
	Begin evacuation and sheltering coordination to move medical equipment and supplies to Base Staging locations (Division 1 Houston and/or Division 2 San Antonio).	DSHS
	Prepare to deploy NDMS assets for aero-medical evacuation. Medical Transportation assets to report to San Antonio ARCC Staging (Division 2).	DSHS and Federal HHS Incident Response Coordination Team (IRCT)
	Identify Air Hub locations. Designate Air Hub Incident Commander. Provide designated locations to all partners, local, state and federal.	DDC Region, SOC and DSHS ESF-8
	Provide MOC/RAC with PMR for Hospitals. Provide them with "Just- in-Time-Training" for how to request evacuation assistance See Attachment 7 for flow process. *Note: request for PMR may begin at 84 hours but in no case will it be later than 72 hours.*	Hospitals and RACs, EOCs and DDC SOC (ESF-8 DSHS)-SMOC
	Contact ESRD network for population to be evacuated with ESRD medical issues.	DSHS/DADS
	Verify and activate state and federal personnel assets. Request and Deploy NDMS and FMS personnel and resources to identified locations.	DSHS and IRCT Incident Response Coordination Team - HHS

H-Hour	Activity	Responsibility
H-96 Continued	Notify Joint Patient Movement Team (JPMT)/Air	IRCT Incident Response Coordination Team - HHS
	Activate contracts for nurses, EMTs, Paramedics for evacuating buses. Must initiate at H-84 for Valley operations.	DSHS Logistics
	DSHS EMS Ambulance Support Team activated	DSHS Logistics
H-84	Formally request hospitals provide status report utilizing designated forms: • Shelter-in-Place • Evacuate • Evacuate with Assistance	DSHS though RACs, EOC/MOC
	Deploy State and Federal medical transportation assets to Division Base Camp staging areas for evacuation of medical patients.	SOC and DSHS ESF-8 IRCT – HHS, DoD
	State ESF-8 conducts additional conference calls to determine readiness of Air Hubs (Note: Air Hubs must be in place no later than H-72).	DSHS & Federal Partners
	Identify Air Hubs ***activation time***, and deploy personnel to AMP locations within 4-hours.	IRCT Incident Response Coordination Team - HHS
	Evaluate need for Federal Medical Shelter support and request if needed (this includes FMS and/or staffing support and/or medical assets).	SOC & DSHS
	RAT and MIST establishes **ESF-8 Incident Support Team** at the EOC/DDC designated location(s).	DSHS
	ESF-8 Incident Support Team establishes coordinated communication processes for ESF-8 with: • DSHS SMOC • Division 1 and/or 2 • Evacuation MOC • Receiving MOCs • Embarkation Sites and Air Hubs • TxMF & Federal response partners/agencies	DSHS SMOC, MIST, Division 1 and 2 Regional MOC
	Embarkation Sites, Fuel Sites, Comfort Stations and forward Staging Area designated and set up.	SOC and TxMF
	Pre-stage assets (Division 1 Houston or Division 2 San Antonio staging areas) • Ambulances and ALS Buses (request need to TDEM) • Supplies and Medical Shelter Push Packs • Federal Medical Station (FMS) • Medical personnel (clinicians and coordinators) • Request Rotor Wing and Ambulance aircraft • Para-transit vehicles	SOC, DSHS, Federal Partners
	Request Health Service Regions (HSR) provide the locations of: • Reception centers • Medical Shelters • Long term care facilities /shelters	DSHS & HSR

H-Hour	Activity	Responsibility
H-84 Continued	Hospitals submit PMR for Ground and Air medical transportation assistance following the 14 Step process listed in Attachment 7. Note: NDMS/GPMRC need enough lead-time to begin patient movement at H-72 hours so PMR must be submitted at H-84.	Hospitals, Evacuation MOC ESF-8 Incident Support Team, Division MOC, DSHS Federal Partners
	For Valley operations- Ambulance Transportation assets notified to begin deployment to evacuation region. PMR must be submitted from LRGV medical facilities beginning at H-84.	SOC and DSHS
	TDEM and DSHS will make push for commitment from hospitals to declare whether they will evacuate or shelter-in-place.	DSHS
	DSHS issue a request to have all PMR's submitted to the Regional MOC and to the SMOC at the 72-hour time frame.	DSHS
H-72	Continue to monitor status of: • Medical Evacuation • Nursing homes & Assisted living facilities • Hospitals • Transportation of medical patients/people • End Stage Renal Dialysis Network (ESRD)	DSHS/DADS
	ESF-8 Incident Support Team coordinates filling out and filing of PMR for ground or air requests for medical transportation support.	DSHS ESF-8 Incident Support Team and MIST
	Identify number and locations of designated medical shelters. Provide data in Sit Rep report and WebEOC.	DSHS Austin and Health Service Regions (Assisted by BCFS, ARC, Mass Care)
	Deploy Federal Medical Support (FMS) to designated medical shelters locations if required. Begin set up of FMS at identified sites.	IRCT
	ESF-8 Incident Support Team and Evacuation MOC perform status check from hospitals regarding request for evacuation assistance. Communicates information to Division MOC and DSHS SMOC.	ESF-8 Incident Support Team, Evacuation MOC, Division MOC, DSHSIRCT
	Medical Incident Support Team members in place at various operational nodes. MIST and ASM personnel assigned to designated Air Hubs as part of the Ambulance coordination process.	DSHS Austin Operations MIST, ASM
	ESF-8 Incident Support Team and Evacuation MOC request update for SIP hospitals that may require augmentation. Note: Current SIP Form must be provided to facility.	ESF-8 Incident Support Team, Evacuation MOC, Division MOC, DSHSESF-8
	Federal Partners • Evacuation Liaison Team (AELT)/Medical Air Staging Facilities (MASF) In Place (NDMS Partners & DoD) • Joint Patient Movement Team (JPMT)/Air in place DoD • NDMS in place and Patient Movement can be initiated DoD • Full Staff At Medical Unified Command Cell (all partners work with ESF-8 Incident Support Team, CMOC, and/or RMOC)	IRCT Incident Response Coordination Team – HHS DoD,

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H-Hour	Activity	Responsibility
H-72 Continued	Prepare to receive people with medical needs at Federal Medical Stations (if required). State and federal contracted ambulances/buses /para-transit vehicles are in their assigned location. • (NOTE: This may be acted upon at H-84 for Valley Operations)	HHS & DSHS
	Hospitals identify/declare SIP and report this to the Evacuation MOC and the ESF-8 Incident Support Team.	Hospitals, Evacuation MOC ESF-8 Incident Support Team, Division MOC, DSHSHHS & DSHS
	Hospitals submit PMR for ground and Air medical transportation assistance. Note: Must be submitted at H-84 for LRGV operations.	Hospitals, Evacuation MOC ESF-8 Incident Support Team, Division MOC, DSHS Federal Partners
	NDMS Air Transports: GPMRC creates NDMS mission assignment. Forwards information through designated response process. *Note: GPMRC will forward the same information to the receiving FCC.*	GPMRC, DSHS SMOC, Division MOCs, ESF-8 Incident Support Team, Evacuation Region SOC/MOC, Hospitals
	Confirm placement and availability of federal assets and personnel at all points (Air Hubs and FMS sites). NDMS Air Transports confirmed TxMF Air Assets confirmed	Air Hub Incident Command, EOC, DDC & ESF-8 Incident Support Team, SOC, DoD, TxMF, DSHS
	NDMS/DMAT (5 person Strike Team) will provide oversight and medical assistance to patients at the Air Hub	IRCT- Incident Response Coordination Team, NDMS, Air Hub Incident Command
	At the Air Hub Federal ESF-8 partners are all in place (DMAT/DOD) and prepared to begin receiving patients from hospitals.	ESF-8 Incident Support Team, Evacuation MOC and hospitals, Air Hub Incident Command, EMS-AHATT
	Note: for Valley operations Ground Ops call patients forward for air evacuation no later than H-72. For all other coastal areas evacuation start times will be determined by local officials and facility management, but in no case later than H-60 hours.	Hospitals, Evacuation MOC ESF-8 Incident Support Team, Division MOC, DSHS
	Confirmation of packaging of patients; hospitals begin to prepare patients for forward movement to Air Hubs.	ESF-8 Incident Support Team & MIST, DoD, TxMF
	Local EMS system (augmented by state and federal medical transportation assets) begin moving patients to Air Hubs utilizing the established Air Hub Ambulance Transportation Team - AHATT.	Evacuation MOC and ESF-8 Incident Support Team Division 1 and 2 MOC

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H-Hour	Activity	Responsibility
H-72 Continued	State and federal assets begin movement of people with medical needs from medical facilities and embarkation sites. **NOTE: hospital patient transfers are coordinated through the evacuation MOC, Division MOC, and receiving MOCs using EMSystems.**	Evacuation MOC, ESF-8 Incident Support Team, Division 1 and 2 MOC
	First evacuees leave the Air Hub and Embarkation Points.	State and federal ESF-8
	Begin Reception of Patients at designated sites.	State and federal partners
H-66	Evacuation MOC and ESF-8 Incident Support Team continue coordinate transportation missions and Patient Tracking for Ground and Air medical transports.	Evacuation MOC, ESF-8 Incident Support Team, Division MOC, Receiving MOCs
	Ground Ops for Air Transportation– AHATT continues patient pick-up and movement to Air Hub for Military Air Evacuation.	Local EMS-AHATT, Evacuation MOC, ESF-8 Incident Support Team, Division MOC
H-60 to H-54	Hospitals/ and the Evacuation EOC/MOC and Division MOC • monitor and report Medical Facility support needs to EOC/DDC/SOC; • Provide support for movement of people with medical needs to SIP facilities or out of region.	SOC, ESF-8 DSHS SMOC
	Re-assess operations to confirm placement and availability of state and federal assets and personnel at all points.	Ground Operations and EMS-AHATT & Dispatch
H-54 to H24	Patients continue to move: • Evacuation facilities to receiving facilities/hub cites • Hospitals to Air Hubs for transport to FCC • Embarkation points to receiving sites.	State and federal ESF-8
	• Keep Evacuation & Shelter Information Updated Through JIC • Provide Medical Needs Report • Coordinate Health & Sanitary Need Of Shelters • Continue To Operate Medical Shelters • Continue To Monitor Bed Census • Monitor the Evacuation & Shelter Of Persons Having Mobility Limitations, Including Persons In Nursing Homes, Hospitals, Group Homes & Non-Institutionalized Persons • Provide Rapid Intervention Team for quick response to emergency transfers	State and federal ESF-8
H-48	Continue Ground and Air (NDMS) Patient Evacuation Finalize preparations for Shelter-in-Place activities.	DSHS & Federal partners

H-Hour	Activity	Responsibility
H-54 to H24	• Continue To Provide Medical Needs Report • Continue To Coordinate Health & Sanitary Need Of Shelters • Continue To Support Operation Of Medical Shelters • Continue To Monitor Bed Census • Continue To Monitor The Evacuation & Shelter Of population with medical needs Including Persons In Nursing Homes, Hospitals, Group Homes & Non-Institutionalized Persons • H-48 Rapid Assessment Team - RAT deployment to expected landfall area. CAT One placed on alert for possible deployment.	IRCT - Incident Response Coordination Team SOC and DSHS
	Begin planning phase to remove/shelter response assets and personnel.	Local, Regional, and state Incident Command
	State ESF-8 conference call held to determine how many patients are still requiring evacuation and determine when operations will shut down in anticipation of tropical force winds making landfall.	DSHS, Federal Partners, ESF-8 Incident Support Team, Evacuation MOC, hospitals
	State ESF-8 conference call held to determine how many patients are still requiring evacuation and determine when operations will shut down in anticipation of tropical force winds making landfall.	DSHS, Federal Partners, ESF-8 Incident Support Team, Evacuation MOC, hospitals
H-40	Determine final patient evacuation transports; initiate plans to shelter-in-place (Note: Air Operations end at H-18).	**SOC**, Federal Partners, DSHS ESF-8, DDC, Local Incident Command, Evacuation MOC, ESF-8 Incident Support team
	Ground OPS-monitors dispatch plans for completion within timeframe to discontinue ground evacuation transports.	EOC/DDC, Evacuation MOC, ESF-8 Incident Support Team
	ESF-8 Incident Support Team and USAR establish communication link up and begin planning for pre-storm SAR and begin plans for post-strike activities. *Note: must determine safe location for Shelter-in-Place for ESF-8 and ESF-9.*	ESF-8 and ESF-9
	1. Continue To Provide Medical Support. 2. Notify SAR of SMART locations.	Local EMS, Evacuation MOC, ESF-8 Incident Support Team
H-36	**Contra Flow Begins!** **Ground Transportation Assets must be in Place** **Only Air Transportation Assets can re-enter**	SOC
H-36	Deploy Ambulances to shelter clusters following evacuation. Note: Remaining state and federal transportation assets may be pulled out of impact region. Time frame for removal will be determined based in incident factors.	EOC/DDC & DSHS
	Planning for Post-storm needs initiated and evaluated. Coordinate with state FCE Team (DSHS RAT and MIST).	SOC, ESF-8, DSHS SMOC

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H-Hour	Activity	Responsibility
H-30	Notify HSRs and RACs of potential deployment of assets for emergency health care support to impacted region.	DSHS SMOC
H-24	Confirm status of hospital evacuations and final shelter–in-place population and determine frequency of reporting.	SOC ESF-8, DSHS SMOC
	Command Assistance Team - CAT 1 pre-staged and ready to deploy to support RAT post landfall. Another CAT put on alert to deploy to affected regional ROC, if needed.	DSHS Austin and HSR's
	Confirm Status of Nursing Home evacuations and final shelter-in-place population and determine frequency of reporting.	SOC ESF-8, DSHS and DADS
	Air Hubs are demobilized and conduct a close out report via phone to the RAC/Regional MOC, DDC and state ESF-8.	SOC & ESF-8 DSHS SMOC
	Evacuation City/County EOC, MOC, and ESF-8 Support agencies incorporate shelter-in-place plans	Evacuation MOC, SOC & ESF-8, DSHS SMOC
H-20	Update status of nursing home evacuations and final shelter-in-place population and determine frequency of reporting	SOC ESF-8, DSHS and DADS
H-18	Demobilization of Operations at Air Hubs.	Air Hub Incident Commander
	Patient Movement Operations for ground and air end.	RAC/Regional MOCs, County EOCs, State ESF-8
	Medical support personnel evacuated/sheltered for storm. Note ALL "contract" assets will be removed from the theater at H-12 Patient Movement Operations for ground and air end.	ESF-8 partners RAC/Regional MOCs, County EOCs, State ESF-8
	Hospitals and Nursing Homes submit listing of Patients, Staff, and Guests for potential rescue post-storm. Finalized SIP Forms submitted to Evacuation MOC, ESF-8 Incident Support Team, Division MOCs, DSHS SMOC. **Forms distributed to Search and Rescue (SAR) -Texas Task Force 1.**	EOC/DDC/SOC ESF-8 DSHS and DADSESF-8 partners
	Evacuation MOC to finalize SIP and SMART location listing for ESF-8.	Federal and State ESF-8
H-12	Update status of nursing home evacuations and final shelter-in-place population.	DSHS and DADS
	Based on final impact location, begin identification of actual risks and impacts to communities and healthcare infrastructure.	SOC, DSHS and Federal Partners
H-12 to H-0 Hours	Evacuation MOC to finalize SIP and SMART location listing for ESF-8.	Federal and State ESF-8

H-Hour	Activity	Responsibility
H-12 to H-0 Hours	Begin community assessments for sanitation, facility inspection, issues affecting repatriation, etc., in impacted areas such as: • Condition of medical support infrastructure to provide for Medical Patients/population return • Acute care medical support • Durable Medical Equipment (DME) support • Nursing home support • 911/emergency room support	DSHS & DADS
H-6	**Integration of ESF-8 and ESF-9 activities begins.**	DSHS and USAR
H-0	Begin community assessments based on reports from MOCs and HSR for: sanitation, facility inspection, issues affecting repatriation, etc., in impacted areas such as: • Condition of medical support infrastructure to provide for Medical Patients/population return • Acute care medical support • Durable Medical Equipment (DME) support • Nursing home support • 911/emergency room support	DSHS, Division MOCs, ESF-8 Incident Support Team
Re-Entry Phase R = 0	Establish communications with hospitals to establish status of capability.	Local EOC/MOC DDC, ESF-8, MIST
	Determine access avenues for approach and departures routes for medical transportation assets.	SOC, Federal Partners, TxMF, USAR
	Establish Emergency Health Care. • Assess local emergency health care capability • Activate regional mobile medical assets as required • Assess need for potential deployment of DMAT	DSHS, DDC, EOC Local EOC/DDC
	Determine/Assess potential deployment for Disaster Medical Assistance Team.	SOC and Federal Partners
	Work with SAR/TxTF-1 to establish medical "pick up" evacuation points for people with medical needs. Search and Rescue • Reconvene patient evacuation • Establish triage and treatment point • Medically support Search and Rescue (SAR) • Provide medical logistics support • Determine/Assess potential deployment for Disaster Medical Assistance Team	Evacuation MOC, ESF-9 TxTF-1, ESF-8 Incident Support team EOC/DDC SOC -DSHS SOC and Federal Partners
	Determine Status of local EMS transportation assets and capabilities. Augment with state and federal transportation assets as necessary.	Local EOC, DDC, Evacuation EOC/MOCs
	Establish communication with FEMA, DDCs, CDC, DSHS and regional and local public health established in the field.	SOC, SMOC and Federal Partners DSHS RAT CAT & MIST
	Initiate communications and begin damage assessment for hospitals and long-term care facilities.	DSHS & DADS

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H-Hour	Activity	Responsibility
Re-Entry Phase **R = 0**	Organize communications between response agencies. Establish points of contacts, locations, and capabilities for ERs, Hospitals, DMAT, etc. *Establish redundant communications.*	Evacuation EOC/DDC, Evacuation DMOC, SMOC & Local, state and federal ESF-8 partners
R + 6	Determine emergency room and DMAT team contacts and set up data collection system at emergency care points.	SOC/DSHS and Federal Partners
	Complete initial community/regulatory assessments and allow cleared facilities to re-open.	Local Emergency Management, DSHS
R + 24	Disaster Mental Health: Apply for Substance Abuse and Mental Health Services Administration (SAMHSA) grant – time sensitive.	DSHS
R + 48	Continue to support all ESF-8 related activities: SAR, Patient Evacuation, Shelters, PODS, CISM, vector control, etc.	Federal, state and local health agencies
R + 72	Continue to support all ESF-8 related activities: SAR, Patient Evacuation, Shelters, PODS, CISM, vector control, etc.	Federal, state and local health agencies

Definitions:
- H-Hour is the time of projected onset of tropical force winds striking the coast of Texas.
- "R" The "Re-Entry Phase" is initiated as soon as possible after the event has occurred. There is an unknown period of time between H-Hour and R-Hour during which the hurricane will have made landfall and beings moving inland. In a hurricane, this occurs after tropical storm force winds have subsided. This is the time when conditions allow for the Texas Re-Entry Task Forces to enter into the impact zone or evacuation zones.

ATTACHMENT 2 – ESF-8 PUBLIC HEALTH AND MEDICAL RESPONSIBILITIES

The Texas Department of State Health Services (DSHS) is responsible for ESF 8 activities within the State of Texas. DSHS coordinates all state-level medical, public health and mental health support activities during large-scale emergencies. In large-scale evacuations DSHS has the following responsibilities as the state ESF 8 lead agency:

A. Coordinates resources with and between medical facilities, EMS, and other critical healthcare operations and functions. Provides medical surveillance and patient tracking.

B. Coordinates medical shelters support with Department of Aging and Disability Services (DADS), Department of Assistive and Rehabilitative Services (DARS), and the DSHS Health Service Regions (HSR).

C. Notify HHS Region VI Regional Emergency Coordinator of possible evacuation of medical facilities.

D. Coordinate evacuation needs and progress with SOC.

E. Request assets and assistance from other ESF functions in the SOC.

F. Coordinate medical care for Medical Shelters and general population shelters.

G. Report on ESF 8 issues through situation reports (SIT/REP) to SOC.

H. Forward medical SIT/REPs to Federal ESF 8 partners.

I. The ESF 8 desk at the SOC along with the DSHS SMOC.

   1. Tracks all ground medical transportation assets.

   2. Requests Federal medical transportation assets.

   3. Credentials and placards medical transportation assets.

   4. Provides Medical Incident Support Team to assist the local EOC with the coordination of state assets provided to support local evacuation efforts at the local Ambulance Deployment Coordination Centers.

   5. Provides a liaison to the state and federal command centers.

ATTACHMENT 3 – MEDICAL SUPPORT RESPONSE TEAMS

The purpose of Attachment 3 is to provide a descriptive overview of the types of teams that may be utilized during a large-scale evacuation of multiple coastal healthcare facilities and people with medical needs. In addition, the document provides the composition of the team, the activities and general missions associated with each of the teams. Terms used by DSHS may not be the same as terminology used by local responders.

A. FACILITY EVACUATION TEAM

1. The Facility Evacuation Team refers to the staff within the facility that has responsibility for safe evacuation of the patients/residents within the facility. This team is required to:

    a. Categorize their patients utilizing the criteria within this document,

    b. Submit the Patient Movement Request (PMR) to their local Emergency Operation Center

    c. Triage patients utilizing the criteria within this document,

    d. Coordinate the evacuation process to coincide with the designated arrival of transportation assets

    e. Initiate the movement of patients to waiting transportation assets and assist in the loading of patients and in some cases travel with and provide care to patients being transported.

2. Team Make Up

    a. FACILITY PATIENT LOAD OFFICER (REQUIRED FOR EACH FACILITY)

        1) Meets with the Ambulance Strike Team Leader to coordinate patient loading and transportation.

        2) May meet with a Medical Incident Support Team (MIST) member to coordinated large-scale movements and Air Hub operations.

    b. FACILITY TRIAGE TEAM – MUST COORDINATE WITH.

        1) Load Team

        2) Ambulance Strike Teams Leaders.

        3) Medical Incident Support Team (MIST) members to coordinated large-scale patient movement and Air Hub operations.

3. Team Activities/Objectives

    a. The facility must have an "evacuation plan"

    b. Responsible for notification of:

        1) Facility Evacuation Team members.

        2) Local Evacuation Partners – first responders (9-1-1, EMS, Fire, Police, Public Health).

        3) Emergency Management and the EOC/MOC and

    c. Provide patient data to EOC/MOC: names, acuities, etc., utilizing the designated format; WebEOC, EMTrack, PMR etc.

    d. Provide staff and medical equipment and assets for transfer, and coordinates movement with assisting Local Evacuation Partners - first responders (9-1-1, EMS, Fire, Police, Public Health).

    e. Must have ability to communicate with the Facility Evacuation Team, local Movement Control Team (led by Emergency Medical Services-EMS, and Emergency Management-

EOC, Note: may be assisted by Regional Advisory Council-RAC, MOC and/or Medical Incident Support Team).

1) Phone, Fax, Radio

2) EMSystem, EMResource, WebEOC, etc.

f. Must utilize the designated "patient tracking system" (WebEOC, EMTrack, etc.) during evacuation.

B. MEDICAL INCIDENT SUPPORT TEAM (MIST)

The Medical Incident Support Teams (MIST) members assist in establishing the coordination and communication of all ESF-8 activities between all of the responding support agencies. The MIST assists in coordinating the integration of state and federal assets into a regions overall evacuation objectives. The MIST helps to establish the ESF-8 Incident Support Team located in the DDC and provides the point of contact for local emergency management to access state and federal resources. The Medical Incident Support Team will work with the DDC Captain to determine the optimum location for the ESF-8 Incident Support Team to conduct health and medical activities. Once established, this team will provide the conduit for communication links between all response agencies.

1. MEDICAL INCIDENT SUPPORT TEAM (MIST) MISSION

   a. Objective 1: Assist in Health and Medical Response Activities. The MIST will respond to a region that requires assistance in an evacuation effort, make contact with the DDC and the regional evacuation support agencies, and provide support as requested to the region's medical response efforts. This involves establishing communication processes with the region's emergency response agencies and advising them of the assets and support that is being made available from the state/federal response efforts. Although the bulk of their efforts will center on coordination of the evacuation of MEDICAL POPULATION people, there may be other taskings performed as determined by the DDC or local incident command.

   b. Objective 2: Destination Determination, Patient Tracking, and Notifications. The MIST will work with the evacuating region's EOC and DDC and the receiving EOC and DDC to support health and medical (ESF-8) activities. Some of the activities that the MIST will perform include:

      1) Work with local officials to coordinate requests for medical transportation assets.

      2) Work with local officials to identify and establish suitable ambulance staging areas.

      3) Work with the local EMS Ambulance Dispatching Centers to coordinate ambulance deployments to evacuating facilities.

      4) Assist in the coordination of patient transport activity.

      5) Provide the necessary medical population evacuation information to the receiving regions/cities. This information will provide receiving communities with the data necessary to make proper preparations at their reception centers and medical facilities. The Medical Incident Support Team's ability to provide specificity of patient information (both in volume and acuity) to receiving cites will allow for better management of the incoming patients and better patient care during the evacuation process.

2. ADDITIONAL DETAIL ON THE MISSION OF THE MEDICAL INCIDENT SUPPORT TEAM (MIST)

   Once deployed the MIST will make contact with the DDC (or if not operational - the requesting counties' EOCs) and perform any or all of the following objectives.

a. Establish contact and communication processes with requesting region's Incident Command Structure

   1) DDCs Level

      a) Health Service Region (HSR).

      b) DDC Captains

      c) TDEM District Coordinator's and Regional Coordinators

   2) District Medical Operation Center (DMOC)

      Work with TDEM, the DDC, and Health Service Region to establish the location of the DMOC (location for the ESF-8 Incident Support Team) and begin the process of establishing communication links with various agencies and response partners.

   3) Local EOC/Incident Command.

      Establish the communication links into the local EMS structure to facilitate the deployment of any incoming "Ambulance Strike Teams", medical assets or individual units upon request from the evacuating region's EOC/MOC.

b. Assist in identifying proper locations for Ambulance Staging and Rehab Areas. Provide information to DDCs, SOC, SMOC and receiving division DMOC.

   1) Assist as necessary in staging of Ambulances Strike Teams.

   2) Assess and identify phone numbers and/or radio compatibility with support agencies and responders.

   3) Establish necessary communication links with evacuating facilities. Establish points of contact & phone number with either the respective EOC or DMOC or facility(s) as necessary.

c. Identify/confirm locations of **Embarkation Points**. Provide information to DDCs, SOC/DSHS SMOC and receiving division District Medical Operation Centers (DMOC).

   1) Locations.

   2) Points of Contact (TxMF staff).

   3) Phone numbers and/or radio compatibility.

d. Identify/confirm locations of Air Hubs. Provide information to SOC, DSHS SMOC and receiving DDCs, and regional MOCs.

   1) Locations.

   2) Points of Contact (command staff for Air Hub Command, TxMF, NDMS, MASF).

   3) Phone numbers and/or radio compatibility.

e. Identify location of and establish contact and coordination with the Air Hub IC.

   1) MIST Team members

   2) Ambulance Staging location and team

   3) TxMF command staff.

   4) NDMS command staff.

   5) MASF command staff.

   6) Local EMS and the Air Hub Ambulance Transportation Team.

f. Provide support to Urban Search and Rescue efforts (USAR)

   1) Provide for Ambulance support.

   2) Provide "Patient Tracking" documentation.

   3) Provide communication of patient transports for USAR to receiving locations: hospitals, embarkation hubs, etc.

C. AMBULANCE STRIKE TEAMS

1. A configuration of ambulances leads by an Ambulance Strike Team Leader with common communication capability that responds to major medical events. These teams can be assembled and deployed by three methods:

   a. Medical units brought into an event by activation of a regionally established response plan.

   b. Medical units brought into a major response utilizing state contracted ambulance providers.

   c. Federal Medical Units pulled together by combining medical units provide by FEMA and organized into Ambulance Strike Teams when they arrive in Staging in San Antonio or Houston.

   Note: If Medical Units have been deployed into a region and they arrive as single resources, they will be assembled into Strike Teams to facilitate proper command and control of these vital assets. This can occur by local Incident Command or be handled with the assistance of a Medical Incident Support Team.

2. Ambulance Strike Team Make-Up

   a. 5 to 7 Type III Ambulances with staffing.

   b. Minimum two person crew; EMT and EMT-P or 2 EMT-P per ambulance.

   c. Ambulance Strike Team Leader with transportation vehicle.

   d. Common communication between designated team assets.

      1) Radio

      2) Cellular phone

3. Team Purpose

   a. Ambulance Strike Teams will respond to mission assignments and perform as directed. They may be assigned to support the following evacuation locations:

      1) Evacuating region EMS Response System.

      2) Specific Hospital Evacuation missions.

      3) Specific Nursing Home Evacuation missions.

      4) Embarkation Support.

      5) Shelter Support.

      6) POD Support.

      7) Air Hub Ambulance Transportation Teams (AHATT).

      8) Other missions as assigned.

   b. Ambulance Strike Team personnel are required to perform the following tasks:

      1) Proper triage to assist in matching the patients to the most appropriate transportation asset.

2) Capability to communicate with their Strike Team Leader, Medical Incident Support Team, District Medical Operation Center (DMOC)

3) Capability to coordinate activities with local EMS Ambulance Units and local EMS Dispatch Centers.

4) Communication of location and availability at all times.

5) Notification of completion of mission assignments.

c. Ambulance Strike Team Leader – an EMS supervisor suitably trained and qualified to effectively manage and direct a strike team of ambulances to effectively respond to a major medical event.

D. AIR HUB AMBULANCE TRANSPORTATION TEAM (AHATT)

The Air Hub Ambulance Transportation Team is established when TxMF and/or NDMS air is requested to support an evacuation of medical patients. The AHATT includes the assets that are assigned to provide transportation of medical patients from the evacuating facility to the Air Hub. The AHATT is led by the AHATT Manager, who is designated by the DMOC.   Note: The following activities are to be coordinated with local emergency response efforts.

The AHATT can request additional support for medical transportation assets by contacting the DMOC (or the regional Ambulance Staging Area if directed to during the duration of the incident). All deployments of medical assets to support the AHATT will be tracked in WebEOC and updated by the Ambulance Strike Team Leaders. The AHATT will coordinate all patient movement with the designated Ambulance Deployment Coordination Center (Local EMS Dispatch).

Airport Hub Ambulance Transportation Team (AHATT) Responsibilities include:

1. Coordinate with Airport IC.

   a. Access to Airport Operations area (AE).

   b. Transportation Security Agency.

   c. Customs & Border Patrol.

2. Coordinate with NDMS (Air Force MASF Lead) for flight manifest.

3. Coordinate and communicate with TxMF.

4. Manage hospital to airport patient movement based on flight manifest. Move patients from hospital to airport on military liters. In order to make military liters available these must be requested before patient load operations occur at the hospitals.

5. Determine EMS asset needs based on patients to be evacuated and planes available.

6. Establish routes and control route flow.

7. Identify the location of the Air Hub Ambulance Staging location if applicable. (Note: the MIST team at the Air Hub determines the necessity of the Ambulance Staging location.

8. Evaluate manifest to establish order of patient movement (least acute first, most acute last).

9. Interface with hospitals "load officer" (person in charge of evacuation process).

ATTACHMENT 4 – AMBULANCE DEPLOYMENT

Medical transportation assets such as ambulances are one of the most limited resources available in a major disaster. Local medical response agencies and all supporting response partners must establish a strong command, communication and coordination element to provide proper management of this critical resource. In addition to this "3C" approach, the triage criteria provided in this document must be utilized to match all medical patients/population with the most appropriate transportation asset. Note: See the Department of State Health Services *Response Operating Guideline - Ambulance Utilization 2012* for specific details on the recommended policies and procedures for ambulance usage during a disaster.

The local EOC and the regional DDC should have a medical operations center as a component of a response to an emergency or disaster. This Medical Operation Center (MOC) is the coordinating element for all ambulance management, deployment, and patient tracking that occurs during a response. This MOC, whether it is at the City/County EOC or the regional DDC, is the point of interaction for all support agencies that are assisting with health and medical response. All questions related to ambulance requests, deployments and dispatches in a region must be coordinated through these Medical Operation Centers.

A. THE MOC IS REPRESENTED BY MEDICAL PROFESSIONALS FROM:

1. EMS, (Note: Local EMS is one of the prime agencies that will be represented in the local City/County MOC)

2. Hospitals representatives.

3. Local Public Health.

4. Regional Advisory Councils.

5. DSHS teams: RAT, CAT, DOG.

6. Health Service Region.

7. Other medical support agencies.

    a. Support from the local Medical Operation Center.

    b. Support from deployed Medical Incident Support Team members.

    c. Command and Control from the evacuation DDC.

    d. Coordination between the evacuation DDC and the appropriate Division 1 or Division 2 Staging Area MOC (Houston-CMOC or San Antonio-RMOC).

B. ACTIVITIES OF THE MOC RELATED TO AMBULANCES INCLUDES:

1. Collection of the following information from each hospital and nursing home:

    a. Patient Movement Request (PMR) forms: request for state and federal evacuation assistance.

    b. Private Patient Movement Report (Hospital closures).

    c. Shelter-in-Place (SIP) information.

2. Provide a medical transportation needs request to the EOC → DDC → SOC → DSHS SMOC so that gaps in resource requirements can be addressed.

3. Receive hospital information for patient and resource tracking.

4. Forward all medical evacuation information to regional DDC ESF-8 MOC and the DSHS SMOC.

5. Establish contact information and working relations with the evacuating healthcare Facilities' Load Officers. Provide triage criteria information to the healthcare Facility Patient Load Officer that will help identify evacuating populations for:

    a. Ambulances.

    b. Ambuses.

    c. Medical Buses (Coach Buses)

    d. "Litter" buses.

    e. Para-transit and Ambulette vehicles.

    f. Air transportation (National Disaster Medical System – NDMS, TxMF, Air Ambulances).

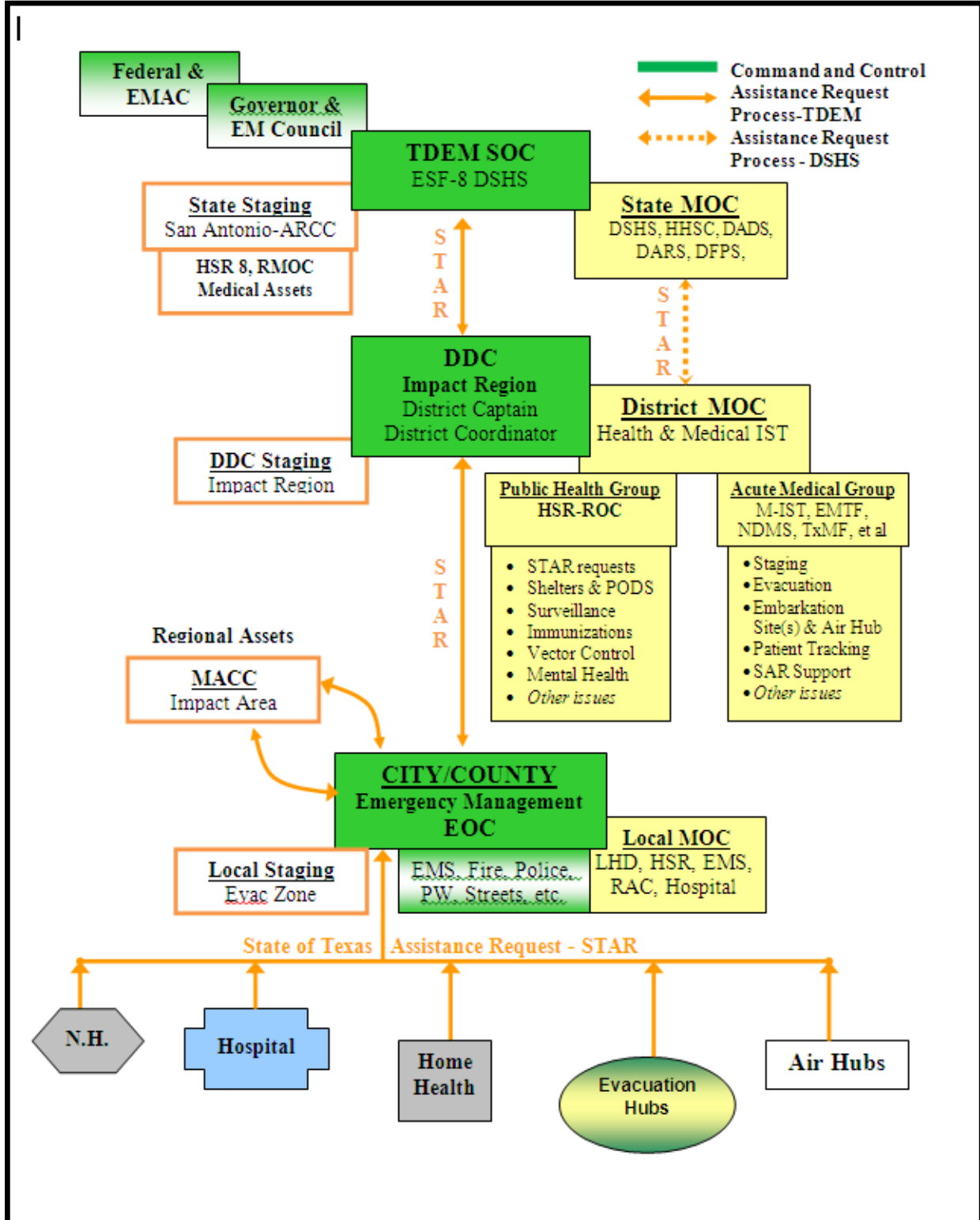6. Coordinate evacuation of people with medical needs from hospital, nursing homes, and home health environments.

7. Dispatch transportation assets to retrieve the patients from hospitals, nursing homes and home health environments.

8. Compile and forward all requests for Military Air Evacuation to the DSHS SMOC so that Texas Military Forces and NDMS can process the request and develop the appropriate "mission assignments" to their response teams

9. Coordinate ambulance resources.

    a. Direct receiving and dispatch activities at ambulance staging area.

    b. Provide for ambulance crew needs and equipment re-stock as needed.

    c. Identify and/or assure formation of ambulance strike teams.

    d. Provide command and control support for deployment of units to evacuation mission.

    e. Ensure all units and crews are either dispatched out of evacuation zone, or are sheltered safely during event (hurricane landfall).

    f. Assist with appropriate demobilization.

10. Provide guidance to evacuation regions on the utilization of the Texas Emergency Tracking Network (Texas ETN), EMTrack, WebEOC, as appropriate, to enable officials to the ability to track the movement of their medical population.

11. Establish methods of transportation for medical evacuees from evacuating facility to the Air Hub-Aeromedical Marshaling Point (AMP) Medical Assistance Staging Facility (MASF).

12. Coordinate with the state ESF-8 Incident Support Teams to assist in filling unmet needs in transportation requirements for:

    a. Facility-to-facility transfers - (for both local and/or out of region)

    b. Facility to embarkation sites

    c. Embarkation sites to receiving destinations.

    d. Facility-to-Air Hubs - establish contact with coordination team

13. Coordinate with the Texas Military Forces (TxMF) for:

    a. Embarkation Point activities

    b. Receiving sites activities

    c. Air Hub activities

14. Assist in the coordination of the Air Hub Ambulance Transportation Team (AHATT) Healthcare facilities to airfield Air Hub or Aeromedical Marshaling Point (AMP).

    a. Establish contact with Air/Ground coordination team (TxMF, MASF)

    b. Identify evacuating populations requiring special medical equipment such as ventilators, intra-aortic balloon pumps, ventricular assist devices, trans-venous pacing, etc.

    c. Identify populations requiring neonatal intensive care transportation.

15. Provide patient data and transportation assets departure times to reception sites utilizing manifests, TexasETN, WebEOC, EMTRAC et al as appropriate.

16. Monitor dispatch plans and mission completion.

17. Estimate and coordinate mission discontinuation of evacuation transports.

DOES THIS PERSON REQUIRE EMERGENCY MEDICAL TREATMENT? → YES → 911-HOSPITAL

STATUS — **TRANSPORTATION**

MOBILITY IMPAIRED Person using Wheelchair — YES → **NEED MEDICAL CARE?** — NO → **PARA-TRANSIT VEHICLE** Equipped to transport wheelchairs

NO ↓ (from MOBILITY IMPAIRED)
YES ↓ (from NEED MEDICAL CARE?)

IS MEDICAL TRANSPORTATION REQUIRED TO EVACUATE?

- Daily dependence upon caregivers but traveling alone?
- Require medical support or monitoring?
- Have extensive equipment needs other than a wheelchair?
- Recent rapid onset of fever or illness, recent hospitalization or surgery?
- Mental health issues?

NO TO ALL → **REGULAR BUS** Typical "over the road" bus used to transport people.

YES ↓

CAN PERSON TRAVEL — YES → **MEDICAL BUS** Equipped with medical staff, equipment and supplies to provide for basic medical needs.

NO ↓

- Does person require medical oxygen at greater than 4 liters per minute?
- Does person require continuous cardiac monitoring?
- Does person require continuous IV medications requiring monitoring? ("to keep open" IV's, peg tubes or vitamin drips do not fit this category).
- Does person have orthopedic injuries requiring appliances or other acute medical condition(s) that prohibit patient from traveling on alternative

NO TO ALL → **LITTER BUS** Equipped with medical staff and basic supplies for medical care to transport person needing litter

YES → **AMBULANCE**

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DSHS Response Operating Guidelines 2012: Ambulance Utilization   (Rev 02/12)

ATTACHMENT 7 – PATIENT MOVEMENT REQUEST FORM – PMR 14 STEP FLOW PROCESS

The Patient Movement Request (PMR) is a fluid document, which does not provide exact patient listings until just prior to the decision to evacuate a specific facility.

The Patient Movement Request (PMR) follows the following **14 Step Flow Process**.

A. DISASTER CREATES NEED FOR PMR – PROCESS BEGINS

1. PMR Form is Distributed

When a large scale (or impending disaster) occurs and there is a potential for utilization of Texas Military Forces and/or NDMS military air assets the PMR process will be used to "trigger" their support. TDEM and DSHS will advise local emergency medical response partners to inform medical facilities that the evacuation PMR form is available. Upon request, DSHS and the deployed M-IST personnel can distribute the following forms:

- Patient Movement Request form
- Aeromedical Evacuation Preparation Checklist (see Attachment 9)

2. Medical Facility submits the PMR

Evacuating medical facilities requesting evacuation assistance will complete the PMR and forward to the completed form their respective EOC/MOC. EOC/MOC with RAC assistance will review the PMR for completeness and:
- Local Ground Assets Sufficient - EOC Staff (Medical Branch or MOC) will review the PMR and determine if evacuation mission can be carried out in part or in full utilizing local resources (either ground or small air assets). If the requested support can be provided entirely with available ground and small air resources then the PMR will proceed no further.
- Local Ground Assets NOT Sufficient - If more medical transportation assets are necessary to carry out the evacuation then the PMR will be forward to the DDC-MOC.
- DDC-DMOC Assigned Ground Assets Available: DDC/DMOC will review the PMR and determine if the evacuation mission can be carried out in part or in full utilizing assigned state resources. If the requested support can be provided entirely with assigned transportation resources then the PMR will proceed no further.
- DDC Assigned Assets NOT Sufficient: If more medical transportation assets are necessary to carry out the evacuation then the PMR will be forwarded to the State Medical Operations Center (SMOC). **This may become the actual notice of request to utilize the large air assets of the Texas Military Forces and/or NDMS.**

3. DDC-MOC submits PMR to SMOC

The DDC-MOC will collect and evaluate the PMR's and ascertain the need for additional state transportation resources. Once the need is determined the DDC-MOC will submit the PMR(s) to the SMOC

- Forward to the DSHS SMOC via e-mail dshsoperations@dshs.state.tx.us **or**
  FAX the document to 512-776-4980

- DSHS SMOC will advise the SOC that a PMR has been received

- DSHS SMOC will determine if state transportation resources are available to fill the request in part or in full.

- If available state transportation resources are insufficient to fully fill the request, TxMF and NDMS will be advised of the PMR.

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4. **PMR Processed by GPMRC**

The DSHS SMOC will review the PMR and forward the completed PMR to the Joint Patient Movement Team (JPMT) who is collated in the DSHS SMOC. The JPMT will transmit the requirement to GPMRC.

5. **Patient Mission Manifest <u>Built</u>**

GPMRC will create the "Patient-Mission Manifest (aka. "Pull Patient-Mission Assignment") and forward it back to JPMT in the SMOC, who in turn will provide the list to the DSHS Operations at the DSHS SMOC.

6. **Patient Mission Manifest <u>Distributed</u> to Emergency Response**

The DSHS SMOC Operations will perform the following:

a. Post the Patient-Mission Manifest - "Pull Patient-Mission Assignment" to the designated DDC-MOC via the designated e-mail address OR FAX the document as directed by the requesting DDC/MOC. MIST can assist in coordinating this step.

b. Call and notify the evacuation regions DDC and EOC of the Patient-Mission Manifest - "Pull Patient-Mission Assignment" so they have visual on the timing of the evacuation operation.

c. Assure that the DDC-MOC personnel (MIST) have distributed the Patient Mission Manifest and the "Pull Patient-Mission Assignment" to the regional EOC-MOC, Air Hub, Air Hub Ambulance Transportation Teams (AHATT) and evacuating medical facilities so they have visual on the timing sequence of the evacuation operation.

d. Post the Patient-Mission Manifest - "Pull Patient-Mission Assignment" in the appropriate event file.

7. **Medical Facility Notification of Evacuation Time – Patients Readied!**

The EOC-MOC will notify medical facility of estimated patient transfer timeframe. Medical facility will prep patient and complete "*Aeromedical Evacuation Preparation Checklist"* for each evacuated patient.

The *Facility Patient Load Officer* and *Facility Evacuation Team* are responsible for triaging individuals and preparing the patients requiring transportation. They must also coordinate with the EOC-MOC and the AHATT the types and the number and of ground transportation assets needed to for the patient movement to the Air Hub..

8. **Ambulance Notification of Patient Pick-Up Time – Dispatched!**

Once the *Patient-Mission Manifest - "Pull Patient-Mission Assignment"* has been received at the Air Hub, the Incident Commander at the Air Hub (AMP) will notify the MIST support personnel of the operation start times. The MIST will notify the Air Hub Ambulance Transportation Team (AHATT) of the operation start time who will print the Hospital Aeromedical Transfer Forms including the patient name and the name of the evacuating medical facilities that are assigned to the arriving aircraft. The MIST and AHATT will distribute the Hospital Aeromedical Transfer forms and maps of the area medical facilities to the ambulance driver.

B. **EVACUATION MOVEMENT BEGINS**

9. **Patients Picked Up (Timing Sequence is critical!)**

The AHATT will coordinate patient pick up utilizing ambulances or ambulance buses. The timing sequence requires arrival at the Air Hub two hours prior to plane arrival. Upon arrival at medical facility the Ambulance Strike Team Leader will meet with the *Facility Patient Load Officer*.

- The evacuating medical facility will complete Hospital Section of the Hospital Aeromedical Transfer Form and keep a copy. Once the patients are "loaded" the AHATT will transport patients to the Air Hub.

- The ambulance crew will complete the EMS Section of Hospital Aeromedical Transfer Form and keep a copy of the Aeromedical Transfer Form upon delivery of patient to Air Hub.

10. Patients Transferred to Air Hub (AMP) (2 Hours Earlier than Plane Arrival)

Patient and equipment is checked in at Air Hub and validated/processed for movement by aircraft by MASF. MASF completes Airworthy Section of Hospital Aeromedical Transfer Form and preps patient for air transport to a receiving Federal Coordinating Center (FCC). If the patient is not suitable for air transport, the MIST will notify the Facility Patient Load Officer or designee for alternative placement.

11. Patients "Packaged" and Loaded On Air Craft

As a rule of thumb, equipment goes along with patients. Receiving medical facilities will coordinate with evacuation medical facility for return of equipment. If equipment is not airworthy, equipment will be replaced with more appropriate air-worthy equipment (known as Patient Movement Items -PMI). Both sets of equipment (replaced and new) will be transported with the patient. Receiving medical facilities will coordinate with evacuation medical facility for return of equipment.

12. Plane Departs - MIST Updates the WebEOC Texas ETN Board

The EMS designee or the MIST designee at the Air Hub will monitor Patient-Mission Manifest - "Pull Patient-Mission Assignment" list to verify patient destination (i.e. returned to medical facility OR transported to FCC destination hospital) and updates the WebEOC Texas ETN Board.

13. Plane Lands at Destination

MIST verifies accuracy of final Patient-Mission Manifest - Pull Patient-Mission Assignment list for each plane and forwards the same to the DSHS SMOC, DDC-MOC, EOC-MOC and Air Hub Incident Commander via e-mail shortly after "wheels up" on the airplane. MASF will notify GPMRC of any changes.

- The local EOC-MOC shall distribute the "*Final Pull Patient*" list to the medical facilities.

- DSHS Operations shall file the "*Final Pull Patient*" list under the "Wheel's Up" folder for the incident.

14. Final Patient Destination List Distributed

Upon arrival of patients at the receiving airport (FCC in either Dallas/Ft. Worth or El Paso for NDMS), and once final medical facility distribution has occurred, the FCC Officer will create and forward the Final Patient Destination form to the Federal ESF 8 partner in the SOC and this list shall be forwarded to the DSHS SMOC Operations Branch. Once received, the SMOC Operations Branch will forward the Final Destination Form to the SOC, DDC-MOC, EOC-MOC, and GPMRC points of contact. The local EOC-MOC will forward the Final Patient Destination Manifest to medical facility(s).

ATTACHMENT 8 – PMR FORM FLOW PROCESS

Diagram 1 – PMR Flow Process

For a Military Air Evacuation the Texas Military Forces and the NDMS must be able to coordinate the arrival of patients to an Air Hub with an appropriate C-17 or C-130. In order to do this they must have notification of the patients so they can build the "Mission Assignment". The following diagram provides a pictorial on the operational steps for the Patient Movement Request Form (PMR) and the Patient-Mission Manifest Air NDMS flow process. It appears to be quite complex but it actually follows the 14 step process found in *Attachment 7.*

AE System Overview

◻	**Local**
◻	**Regional / State**
◻	**Federal**
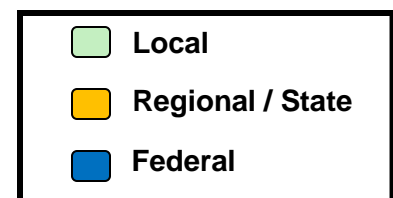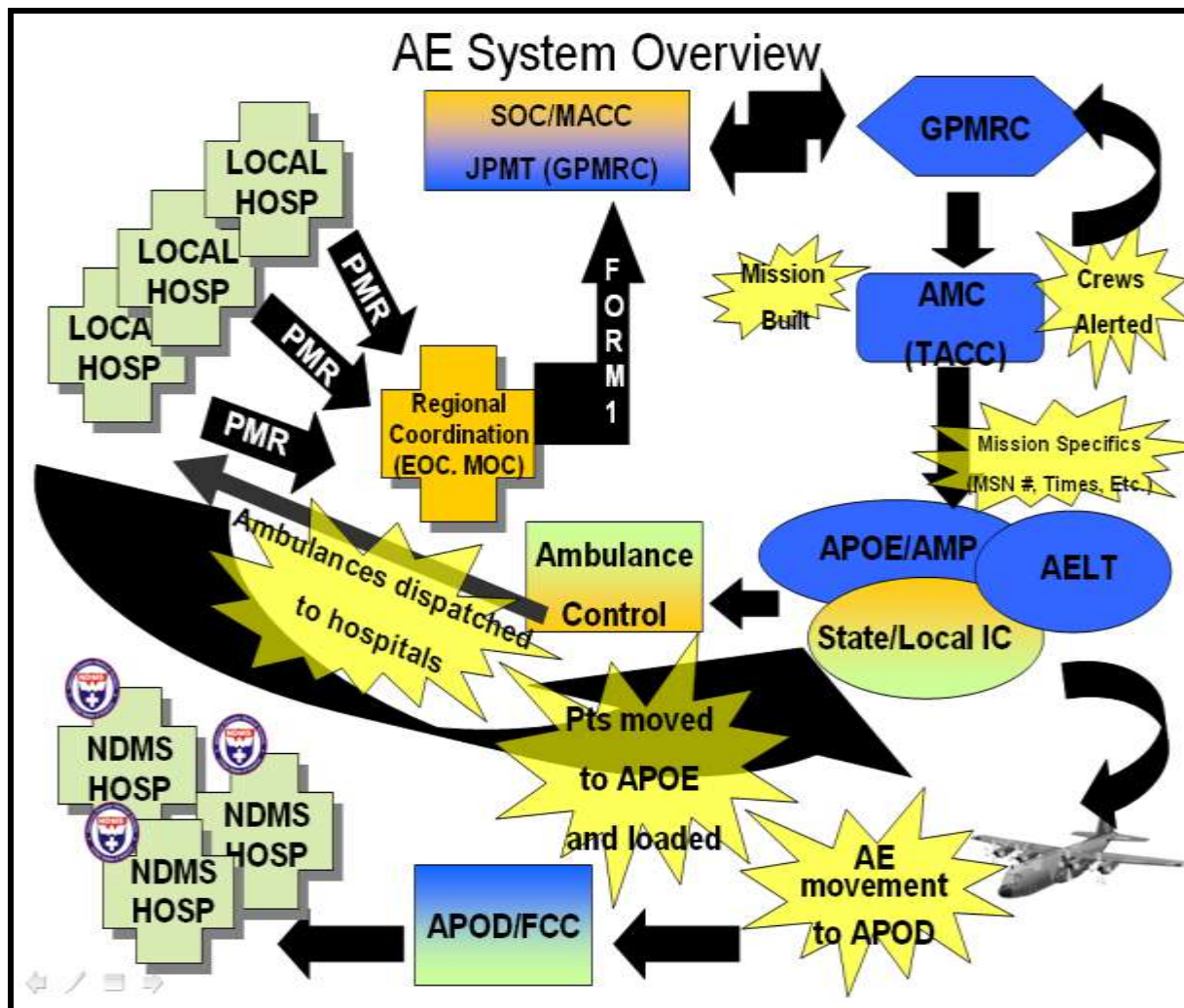
Diagram 2 – Air Hub Ambulance Transportation Team

The diagram is a pictorial of the process of requesting and deployment of transportation assets (ambulances) from the Staging Area, to the medical facilitys for patient pick up, to the Air Hub. The National Disaster Medical System (NDMS) system will receive the patients and transport them to other NDMS facilities in Texas or across the nation if necessary. Non-NDMS Military Air Evacuations (TxMF, etc.) will utilize this same process. In an established air operation, ambulances will be deployed from regional staging to support the Air Hub Ambulance Transportation Team-AHATT. These units will have the specific mission to pick up patients from an evacuating medical facility and transporting them to the designated Air Hub. If additional ambulances are required for the mission, the Ambulance Deployment Coordination Center will deploy additional ambulances from a staging area to the Air Hub. Note: This is not the process for submittal of PMR, this is the operational response to the submittal of the PMR. The map shows coordination points that tell the ambulance crew when to pick up the designated patient(s). This is the process that is utilized once an Military Air Evacuation has begun.
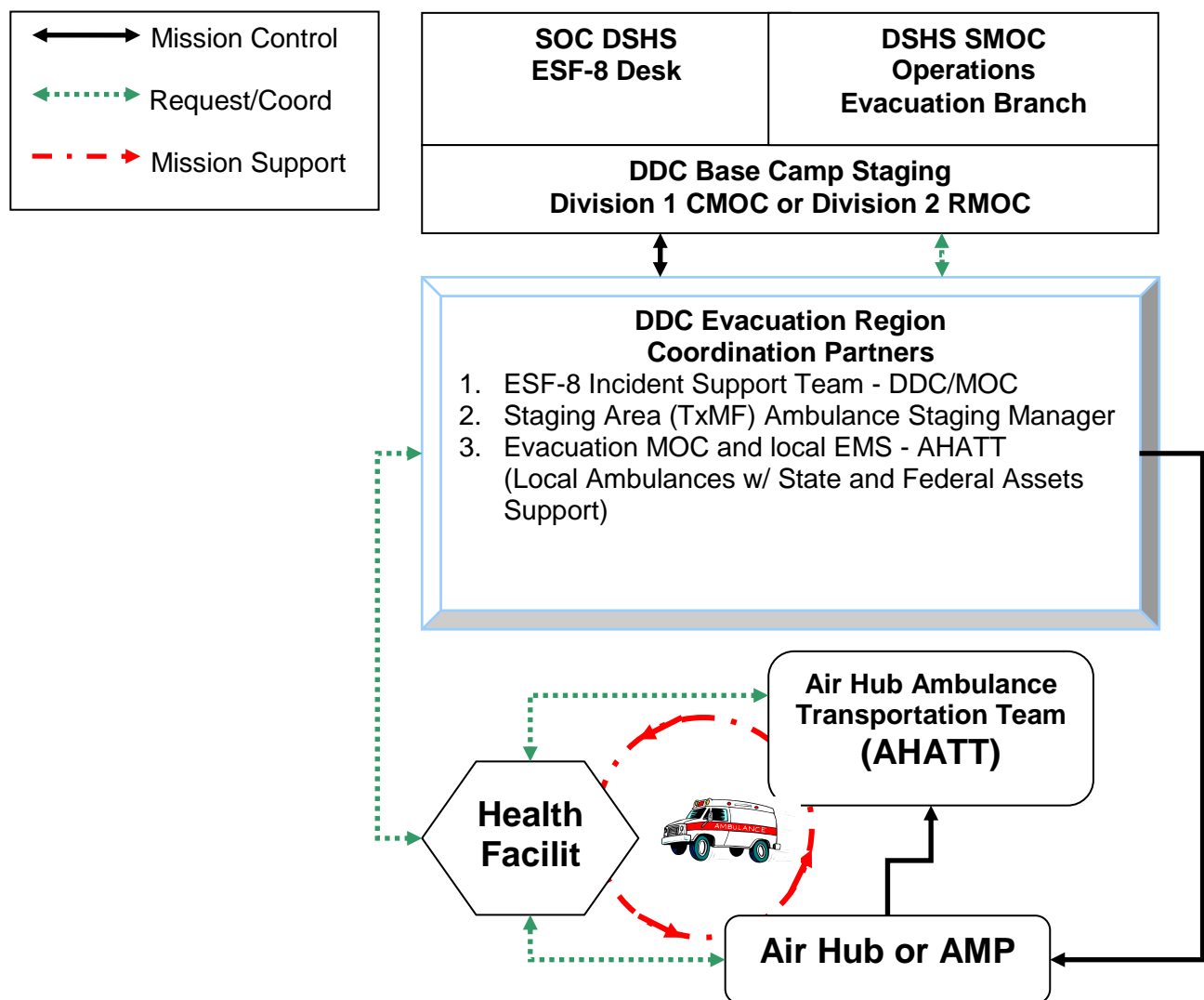
ATTACHMENT 9 – AEROMEDICAL EVACUATION PREPARATION CHECKLIST

FIXED-WING Aeromedical Evacuation (AE)

PREPARATION CHECKLIST for Civilian Patients (Disaster Evacuation)

ITEM	COMMENT	ACCOMPLISHED	
		YES	NO
Personal Documents	Personal (Photo) Identification		
	Emergency (Family) Contacts		
Appropriate Medical Records	Patient Care Summary		
	Patient Care Requirements		
	Medical Alert Tags or Bracelets		
	Prescriptions Authorization		
	X-Rays (if required)		
	Insurance Card or Paperwork		
Medications (Oral and/or Intravenous)	72 hour supply		
Dietary Special Needs	72 hour supply		
Appropriate Clothing (for cold aircraft or inclement weather)	One commercial aircraft size carry on item (Identification attached)		
Authorized Litter			
Durable Medical Equipment • **Portable Oxygen (subject to authorization for flight)** • **Other Durable Medical Equipment**	To support patient during ground transport to medical airhead only. Hospitals should label all equipment they want returned post event.		
Patient Evacuation Kit	Water		
	MRE X 3		
	Blanket (1)		
	Toiletries		

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ATTACHMENT 10 – NURSING HOME EVACUATIONS

A. Nursing homes have transportation agreements in place to evacuate their residents in case of emergency. However, given a large-scale disaster affecting multiple counties in the coastal areas of Texas, a portion of these nursing homes will most likely not be able to procure their pre-arranged transportation.

B. Most nursing home patients will be transported to alternate facilities with which the nursing home has a pre-arranged agreement. The only nursing home residents that will not be transported to an alternate nursing home facility are those who decompensate, or whose current medical condition warrants transfer to the hospital evacuation process. This transfer will be done by ambulance. Non-ambulatory patients will be transferred to partner facilities via ambulance, bus, or properly setup ambus-bus. Ambulatory patients will be transferred via ALS Bus, and those who are wheelchair dependent may be transported via a Wheel Chair Vehicle (WCV).

1. Buses

   The State of Texas and the federal government utilize contracts with coach bus companies to procure buses for medical evacuation (hospitals, nursing homes, and general population without transportation of their own). Many of these buses will have lifts or ramps, making them wheelchair accessible. Each bus can hold up to 40 passengers. These buses will have medical personnel and supplies to provide in-transit care, but medical facilities will be expected to supplement those staff and supplies with their own.

   If a request is made for these assets, command and control of these assets will be provided by the state.

2. Para– transit Seats Wheelchair Vans (WCV)

   For those who need to be transported in wheelchairs, but do not need to be on a stretcher (necessitating ambulance transport) can ride in para-transit vehicles. These are also referred to as Wheelchair Vans or WCV. Many nursing homes have their own WCVs, and use them to transport their residents for routine trips. However, if state assistance is needed for an evacuation, federally contracted para-transit seats will be available. The contract presently provides 3,500 seats that can be used for the evacuation of nursing homes, hospitals, and home health people with medical needs that are wheelchair dependent. NOTE: 3,000 para-transit seats generally require multiple trips from the evacuation area to receiving sites. This means that long term care (LTC) facilities will be asked to evacuate early.

3. Advanced Life Support (ALS) Ambulances

   Currently the state has approximately 200 ambulances under an MOA that can be deployed for medical evacuations. As experience has shown, approximately half of these assets can be activated and deployed into a major disaster. These ambulances can carry two passengers per trip, and come with drivers and the necessary medical personnel to provide in-transit care. A federal contract may add an estimated 300 to 500 ambulances to the medical transportation pool.
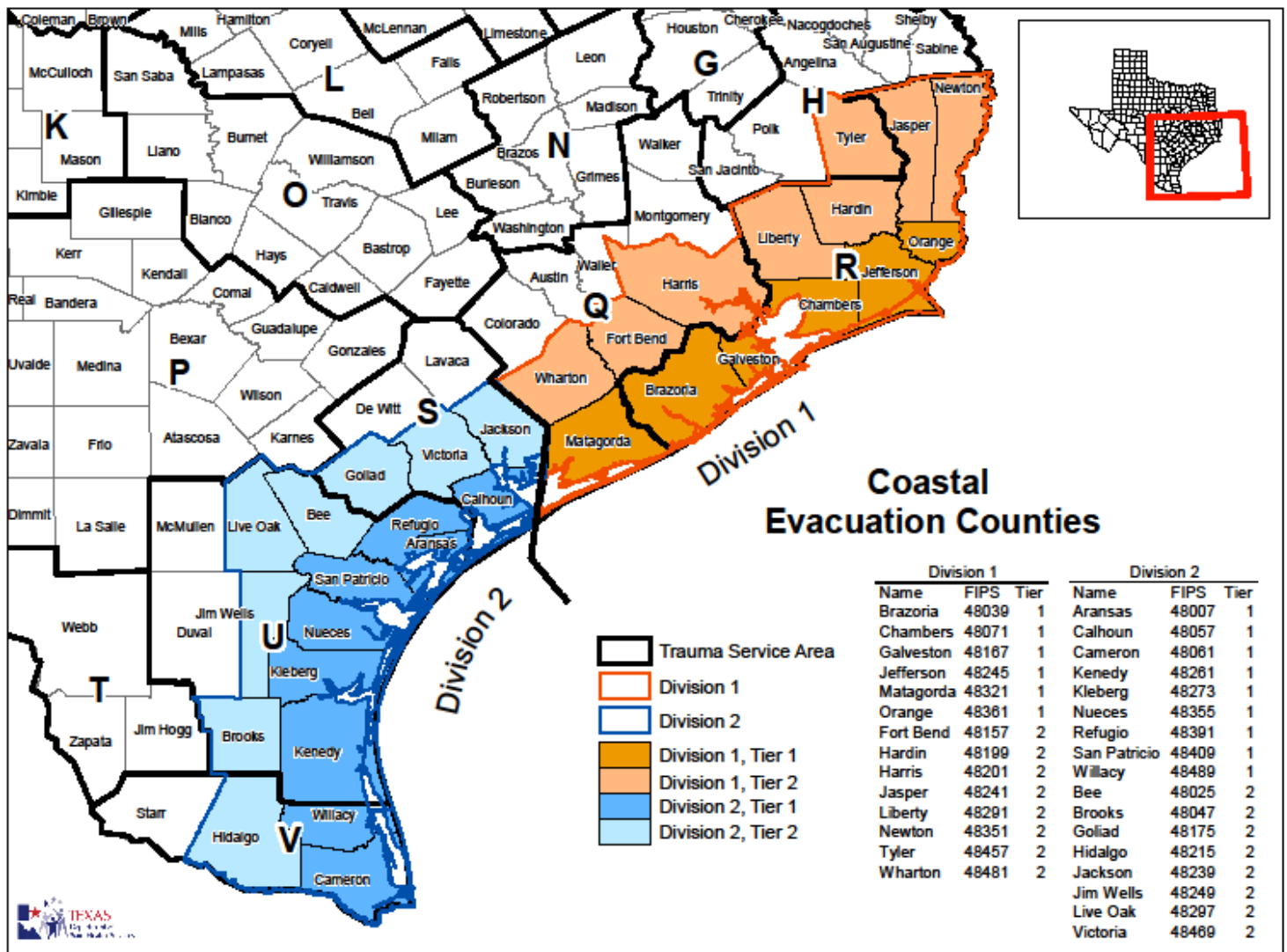
4. Evacuation Staffing

   Having available staff to load, unload, and provide in-transit care for nursing home residents is a vital part of a safe and effective evacuation. A general guide for the staffing requirements is a ratio of one staff member to every ten residents. In addition to nursing staff, augmentation may be required from the county and/or volunteers.

Transportation Requirements for Nursing Homes (This form is subject to change)				
Nursing Home Census Details		Transport Vehicle Needs		
TSA Region or City/ Counties	Census	Ambulances (2per vehicle)	Para-Transit Seats	Buses (Patients and Staff)

C. Nursing homes are responsible for developing and procuring the necessary assets for their evacuation plans. There is an expectation that many nursing homes will succeed in their efforts to self-evacuate; however, those that cannot may request assistance from the city/county. If city/county transportation assets are not available, state assistance will be requested through the DDC.

D. Nursing homes, with input from county officials and emergency personnel, will make the determination to evacuate or to shelter-in-place (SIP). Nursing homes will:

1. Implement nursing home emergency management plans.

2. Activate existing memorandums of agreement or contracts to evacuate patients to pre-identified facilities.

3. Notify their respective city/county EOC on their decision to evacuate.

   If unable to evacuate with pre-identified assets, request evacuation assistance from the city/county EOC.

4. Notify the EOC on the status of their nursing home, the number of patients that require evacuation, the type of patients and whether they are ambulatory or non-ambulatory.

5. The EOC will forward the request to the DDC.

6. The local EOC-MOC and the DDC-MOC will coordinate the deployment of ambulances and buses from the staging/dispatch point to evacuate nursing homes.

7. The nursing home will contact the EOC when transportation arrives and departs, and when the mission is complete.

8. The EOC/DDC/Regional MOC is responsible for:

a. Keeping situational awareness, keeping accurate records of nursing homes that have evacuated and nursing homes that have chosen to shelter-in-place (SIP).

b. Providing non-medical personnel to assist in the loading of patients.

c. Providing evacuation transportation.

E. If county or contracted transportation resources become overwhelmed, the EOC will forward the request to the state through the established communication and asset request process. The state will work with the DDC to procure the requested transportation assets utilizing additional state and federal contracted assets. Transportation will be with standard coach buses, Para-transit seats, ALS Buses, or contracted ambulances.

Source: Texas Department of State Health Services, June 2009 th

Division 1	Division 2
The geographic region south of the south line of Matagorda County	The geographic region north of the south line of Matagorda County
The RMOC is the Medical Operation Center designated by DSHS to assist in coordination of medical support and evacuation activities. This MOC is based in San Antonio and supports the Alamo Regional Command Center	The CMOC is the Medical Operation Center designated by DSHS to assist in coordination of medical support and evacuation activities in this region. The CMOC is based in San Antonio and supports the CMOC-Catastrophic Medical Operation Center.

ATTACHMENT 12 – TEXAS 213RR – COPY

RESOURCE REQUEST MESSAGE ICS-213RRFF TX

Note to Requestor: fill in all shaded areas for expedited service

INCIDENT NAME:	DATE & TIME:	RESOURCE REQUEST #:
COUNTY TRACKING #:	CITY TRACKING #:	DDC TRACKING #:

ORDER NOTES: Use additional forms when requesting different resource sources of supply

Qty.	Unit Type*	Kind (NIMS Rec)	Type (NIMS Rec)	Detailed Item Description (vital characteristics, brand, spec, size, etc.)	Cost (if known)	Demob Item? **

* Unit Type: (case, ea, pallet, etc)   **Demob: Will the item need to be included in Demobilization?

REQUESTOR

Point of Contact Name:	Point of Contact Telephone #:	Facility Name:

Physical Address:	City:	State:	Zip

Requested by (Name & Position):	Contact Telephone #:	Priority:

Supervisor Signature/ Approval:	X	Date:
		Time:
Section Chief Signature/ Approval:	X	Date:
		Time:

LOGISTICS

Logistics Order #:	☐ Equipment ☐ Supplies ☐ Personnel

Name of Supplier:	Point of Contact:	Phone Number:

Fax Number:	Point of Contact e-mail:

Notes:

| Logs Chief Signature/ Approval: | X | Date: |
| | | Time: |

Order sent to: (mark all that apply)   ☐ SPUL   ☐ PROC   ☐ SMOC   ☐ DDC   ☐ OTHER:

FINANCE

Reply or Comments from Finance:

| Finance Chief Signature/ Approval: | X | Date: |
| | | Time: |

Request filled by: ☐ Local   ☐ SMOC   ☐ DDC   ☐ SOC

Route to: ☐ Logs   ☐ Finance   ☐ Requestor   ☐ Documentation

Additional Notes/ Details:

ATTACHMENT 13 – PART 1: AIR AND GROUND AMBULANCE UTILIZATION CRITERIA FOR STATEWIDE DISASTER AND HURRICANE EVACUATIONS

A. Ground Ambulance Utilization Criteria:

Only patients who meet one of following criteria should be considered for transport by ground ambulance (this includes Ambus utilization):

1. Medical oxygen being provided at greater than 4 liters per minute,

2. Continuous hemodynamic and cardiac monitoring is required,

3. Continuous intravenous (IV) medication drip that requires monitoring, such as an IV pump or similar method for delivering precise amounts ("to keep open" IVs, Peg tubes, and vitamin drips would not fall into this category), or

4. Orthopedic injuries that require appliances or other acute medical conditions that would prohibit the patient from traveling on an alternate method of transport (e.g. active labor; cervical traction; unstable pelvic fracture).

B. Air Ambulance Utilization Criteria:

Only patients who meet one of following criteria should be considered for transport by air ambulance:
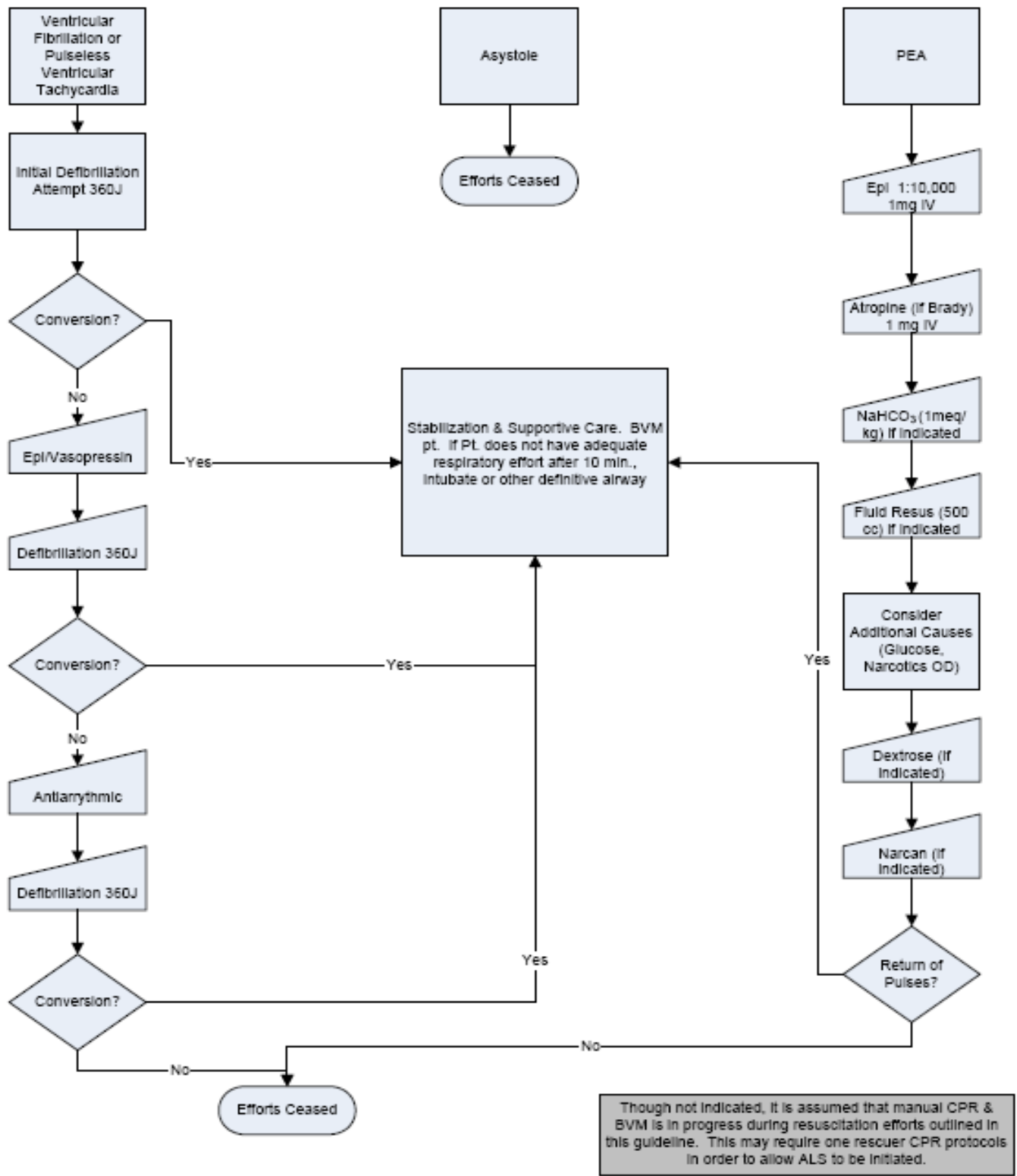
1. Transfers from one critical care area to another critical care area (e.g., intensive care unit ((ICU)); cardiac care unit ((CCU)); pediatric intensive care unit ((PICU)); burn unit);

2. Continuous intravenous vasoactive medications or blood products (e.g., nipride; dopamine; neosynephrine; etc.);

3. Emergent surgical interventions; or

4. Acute medical conditions requiring special interventions (e.g., active labor; evolving stroke; intra-aortic balloon pump ((IABP)); left ventricular assist device ((LVAD)) ; continuous veno-venous hemodialysis ((CVVHD)); isolette transports with advanced life support ((ALS)) interventions; etc.).

Note: these criteria DO NOT apply to Texas National Guard and\or US Department of Defense (NDMS) aircraft used in a region-wide evacuation.

Altered Standards of Care for EMS Operations In Evacuation/large-scale Disaster

After consultation and collaboration with the GETAC EMS Medical Directors committee, the Disaster/Emergency Preparedness Task Force recommends that the following Altered Standards of Care be adopted statewide during hurricane evacuation and other large-scale disasters. (See Attachment 13 - Part 2 below.

Ventricular Fibrillation or Pulseless Ventricular Tachycardia

Initial Defibrillation Attempt 360J

Conversion?

No → Epi/Vasopressin

Defibrillation 360J

Conversion?

No → Antiarrhythmic

Defibrillation 360J

Conversion?

No → Efforts Ceased

Asystole

Efforts Ceased

PEA

Epi 1:10,000 1mg IV

Atropine (if Brady) 1 mg IV

$NaHCO_3$ (1meq/kg) if indicated

Fluid Resus (500 cc) if indicated

Consider Additional Causes (Glucose, Narcotics OD)

Dextrose (if Indicated)

Narcan (if Indicated)

Return of Pulses?

Yes / No

Stabilization & Supportive Care. BVM pt. If Pt. does not have adequate respiratory effort after 10 min., intubate or other definitive airway

Though not indicated, it is assumed that manual CPR & BVM is in progress during resuscitation efforts outlined in this guideline. This may require one rescuer CPR protocols in order to allow ALS to be initiated.

DSHS Response Operating Guidelines 2012: Ambulance Utilization   (Rev 02/12)

ATTACHMENT 14 – TxMF – AERO-MEDICAL EVACUATION OF INPATIENTS IN A DISASTER

Under any conditions one has to believe the level of care will be improved by transferring the patient from one medical facility to another, and be willing to accept the risk associated with the transfer. The **obvious medical risks associated with air transport are hypoxia and altitude changes**. Other considerations will be the mechanical, logistic, and personnel issues required to transport a seriously ill patient on an airplane of opportunity. Texas Air National Guard/Flight Medicine provides the following information for providers:

TRANSIT CONSIDERATIONS

- AIRCRAFT- The transport options are likely to be military aircraft or "aircraft of opportunity"

- ADDITIONAL SUPPORT FOR PATIENT - if the patient is dependent on continuous treatment of some kind e.g. drips, ventricular assist pumps or a ventilator, the transferring facility should anticipate that they need to send supplies, equipment, or even an attendant, with the patient.

- TRANSIT TIME - The transferring physician should consider that it may be anywhere from a couple hours to 12 hours before the patient is back in a hospital comparable to the one the patient left.

PATIENT PREPARATION

- careful fixation and stabilization of any and all lines and tubes

- Cuffs and balloons e.g. endotracheal tubes and foleys, should have their air removed and they should be "inflated" with normal saline.

- A cast should be "bi-valved" well before the flight, there should be no hanging weights for traction, other traction devices should be used if required.

MEDICAL CONTRAINDICATIONS (HYPOXIA AND BAROTRAUMAS)

- A pt. w/ a hemogloblin less than 8.5 (unless known to be chronic and stable) probably should not be transported by air.

- Almost any seriously ill patient will need supplemental oxygen, pulse ox, and to be monitored.

- A pt. less than a week out from a MI or CABG should not be transported by air unless well known to be exceptionally stable

- Post-surgical or post trauma- if all bleeding is known to be stopped, and there are no trapped gases, intra- abdominal, intra-cranial, intra-thoracic, w/in the sinuses or ears or eyes, they may be safe to transport

CONSIDERATIONS

- Stability of surgical repair

- Joint replacements could be dislocated

- Fascial closures could dehisce

- Sutures/staples in the bowel could give way when intraluminal gas expands

- Drains, tubes and lines could get dislodged

- MOTION SICKNESS – esp. for cases of head and neck surgery, so additional precautions should be considered, (antiemetics, wire cutters if needed)

CONTAGIOUS DISEASE

- Isolation is not available

PSYCHIATRIC PATIENTS

- Unstable Psychiatric patients will need attendants. The patient must not be disruptive and they must be able to follow directions, they must be pre-medicated with orders for continuing medication during flight should patient condition dictate this. Restraints may be required.

ATTACHMENT 15 – NDMS: ABSOLUTE CONTRAINDICATIONS FOR FLIGHT

These conditions can be relative contraindications when there is no safe alternative and Shelter in Place is not an option. Risk of alternatives must clearly outweigh the risk of moving fragile patient by air. Regardless, contraindications require advanced sub-specialist and flight medicine consultation and coordination with specialty Aeromedical Evacuation Crew.

A. Any medical condition not stabilized

B. Pregnancy > 34 weeks

C. Hbg < 10

D. Post-op < 72 hours

E. Acute Coronary Syndrome (unstable angina, non-STEMI, STEMI)

F. Any open-heart surgery, craniotomy, spinal cord surgery < 7 days

G. Untreated Pneumothorax (vented needle or tube)

H. Pneumo-cephalus

I. Detached retina or pneumoglobus

J. Seizure within 2 weeks

K. Heart dysrhythmia within 1 week

L. Orthopedic casts

M. Any communicable condition

N. Respiratory isolation including possible TB

O. Agitation or other behavior distracting in flight

P. Any condition or circumstance in the opinion of the Aircraft Commander (ACC) that would endanger the flight